Bundle Audit Committee Part 1 1 April 2019

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3 PART 3 CHARITABLE FUNDS

3.1 Charitable Funds Balances as at 28 February 2019

3.1 Charitable Funds AC 1 April 2019.doc

3.1.1 Appendix D Charitable Funds AC 1 April 2019

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3.1.2 Appendix D Annex A Charitable Funds - Bridgend Funds AC 1 April 2019

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4 PART 4 INTERNAL AUDIT

4.1 Internal Audit Progress Report

4.1 IA Progress Report AC 1 April 2019.pdf

4.2 Directorate Reviews Summarised Analysis

4.2 IA Directorate Reviews Summarised Analysis AC 1 April 2019.pdf

4.3 Core Financial Systems Cash Management

4.3 IA Core Financial Systems AC 1 April 2019.pdf

4.4 Welsh Risk Pool

4.4 IA Welsh Risk Pool AC 1 April 2019.pdf

4.5 Service Change Plans Early Cancer Diagnosis Programme

4.5 IA Service Change Plans Early Cancer Diagnosis AC 1 April 2019.pdf

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4.6 IA Patient Experience AC 1 April 2019.pdf

4.7 Directorate Review Primary Care Compliance

4.7 IA Directorate Review Primary Care Compliance AC 1 April 2019.pdf

4.8 Risk Management

4.8 IA Risk Management AC 1 April 2019.pdf

4.9 Internal Audit Plan 2019 2020

4.9 IA Internal Audit Plan 2019-20 AC 1 April 2019.pdf

5 PART 5 EXTERNAL AUDIT

5.1 Wales Audit Office Update Report

5.1 WAO Update Report AC 1 April 2019.pdf

5.2 Wales Audit Office Audit Plan for 2019 2020

5.2 WAO Audit Plan 2019 2020 AC 1 April 2019.pdf

5.3 Wales Audit Office Structured Assessment 2018

5.3 WAO Structured Assessment 2018 received by AC 14 January 2018 AC 1 April 2018.pdf

5.3.1 Cwm Taf Management Response to Structured Assessment 2018

5.3.1 Cwm Taf Management Response to Structured Assessment 2018 AC 1 April 2019.docx

6 PART 6 ITEMS FOR INFORMATION

6.1 Committee Forward Work Plan 2019 2020

6.1 Forward work plan AC 1 April 2019.doc

7 PART 7 ANY OTHER URGENT BUSINESS

7.1 Items for Referral to other Committees

7.2 Close of part 1 of the meeting - Date and time of next meeting

Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

CWM TAF UNIVERSITY HEALTH BOARD

AUDIT COMMITTEE MEETING

1 April 2019

A meeting of the Audit Committee will be held on Monday 1 April 2019, at Ynysmeurig House, Navigation Park, Abercynon with Part 1 commencing at 9.30am.

PAUL GRIFFITHS
CHAIRMAN

PART ONE – CWM TAF UHB

AGENDA

		LEAD / ATTACHED
PART 1. PRELIMINARY MATTERS		
1.1	Apologies for Absence	Chair/Oral
1.2	Welcome and Introductions	Chair/Oral
1.3	Declarations of Interest	Chair/Oral
1.4	Unconfirmed Minutes of the Audit Committee meeting held on 11 February 2019	Chair **Attachment**
1.5	Action Log	Chair **Attachment**
1.6	Matters arising not contained within the Action Log	Chair/Oral
PART 2. INTERNAL CONTROL AND RISK MANAGEMENT		
2.1	Post Payment Verification Report – End Of Year Update (Sara Jeremiah in attendance for this item)	Director of Primary, Community & Mental Health **Attachment**
2.2	Audit Recommendations Tracker • Medical Equipment and Devices Update Report	Interim Board Secretary **Attachment**
2.3	Procurements and Scheme of Delegation Report	Director of Finance **Attachment**
2.4	Losses and Special Payments Report	Director of Finance **Attachment**
2.5	Financial Control Procedure Medical Variable Pay – Draft Subject to Consultation	Director of Finance **Attachment**

2.6	Standing Orders and Scheme of Delegation including the Review of Declarations of Interest received	Interim Board Secretary **Attachment**

PART 3. CHARITABLE FUNDS

3.1	Charitable Fund Balances as at 28 February 2019	Director of Finance **Attachment**

PART 4. INTERNAL AUDIT

4.1	Internal Audit Progress Report	**Attachment**
4.2	Directorate Reviews – Summarised Analysis	**Attachment**
4.3	Core Financial Systems – Cash Management	**Attachment**
4.4	Welsh Risk Pool	**Attachment**
4.5	Service Change Plans – Early Cancer Diagnosis Programme	**Attachment**
4.6	Patient Experience	**Attachment**
4.7	Directorate Review – Primary Care Compliance	**Attachment**
4.8	Risk Management	**Attachment**
4.9	Internal Audit Plan 2019 - 2020	**Attachment**

PART 5. EXTERNAL AUDIT

5.1	Wales Audit Office update Report	Wales Audit Office **Attachment**
5.2	Wales Audit Office – Audit Plan for 2019/2020	Wales Audit Office **Attachment**
5.3	Structured Assessment 2018 5.3.1 Management Response	Wales Audit Office **Attachment**

PART 6. ITEMS FOR INFORMATION

6.1	Committee Forward Work Plan 2019/20	Chair **Attachment**

PART 7. ANY OTHER URGENT BUSINESS

7.1	Items for referral to other Committees	Oral/Chair

7.2 Close of **Part 1** of the meeting – Date and time of next meeting. Oral/Chair

- 09.00am Monday 13 May 2019

In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it has been resolved that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

CWM TAF UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 11 FEBRUARY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Maria K Thomas	-	Independent Member
Dilys Jouvenat	-	Independent Member

IN ATTENDANCE

Gareth Lucey	-	Wales Audit Office
Sara Utley	-	Wales Audit Office
Steve Webster	-	Director of Finance
Jacqui Maunder	-	Interim Head of Corporate Governance
Simon Cookson	-	NWSSP – Internal Audit & Assurance
Paul Dalton	-	NHS Wales Shared Services Partnership (NWSSP) – Head of Internal Audit & Assurance
Emma Samways	-	NWSSP – Internal Audit & Assurance
Steve Wood	-	NWSSP – Internal Audit & Assurance (in part)
Eifion Jones	-	NWSSP – Internal Audit & Assurance (in part)
Emma Walters	-	Committee Secretariat
John Palmer	-	Chief Operating Officer (in part)

AC/19/031 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting, particularly Simon Cookson, Steve Wood and Eifion Jones, who were all attending on behalf of Internal Audit.

AC/19/032 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Jayne Sadgrove, Robert Williams, Gwenan Roberts, Ruth Treharne and Tim Burns.

AC/19/033 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interests, to those previously notified.

AC/19/034 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 14 JANUARY 2019.**

The minutes of the meeting held on 14 January 2019, were **CONFIRMED** as a true and accurate record.

AC/19/035 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 14 January 2019 was reviewed by Members and the following was **NOTED**:

17/130 – Members **NOTED** that this action was now completed and would be removed from the action log (**removed from the action log**).

18/026 – Members **REQUESTED** that this action was removed from the action log and added to the Forward Look (**removed from the action log and added to the forward look**).

18/077 – Members confirmed that they had received an update from Mark Thomas by email regarding the progress made to address the significant variations and **AGREED** that this item could now be removed from the action log (**removed from the action log**).

18/081/084/097 – Members **AGREED** that these could now be removed from the action log as actions were now complete (**removed from the action log**).

18/099 – Maria Thomas advised that an update had been included in the Audit Recommendations tracker. Members **NOTED** that a closure report had not yet been received.

18/100 – Members **NOTED** that this action was now completed and that a Deep Dive report on Claims Expenditure would now be presented to the March Finance, Performance & Workforce Committee (**removed from the action log**).

18/102 – Members **REQUESTED** that this item was removed from the action log and added to the Forward Look (**removed from the action log and added to the forward look**).

18/103 – Members **NOTED** that this action was now complete and that discussions had been held with the Executive Team in relation to delays being experienced in receipt of management responses. Members **AGREED** that this item could be removed from the action log (**removed from the action log**).

19/007 – Steve Webster requested that this action was amended to reflect that a revised reporting process was required, with a report to be presented on work undertaken year to date and a report outlining the forward plan for next year (**action log amended**).

19/023 – Paul Griffiths to have a discussion with Gwenan Roberts outside of the meeting as to whether steps had been taken to recruit additional resource to capture the raising of concerns. Members **AGREED** to receive an update at the next meeting (**action log updated**).

19/025 – Members **NOTED** that an updated management response would be presented to the April meeting (**action log updated**).

AC/19/036 **MATTERS ARISING**

There were no matters arising.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/037 **AUDIT RECOMMENDATIONS TRACKER**

Jacqueline Maunder presented the report on behalf of Gwenan Roberts. Members **NOTED** that in relation to Internal Audit, there were 42 outstanding recommendations, 35 of which were classed as being overdue but partially completed. In relation to External Audit, there were 30 recommendations outstanding, 17 of which were overdue.

Paul Griffiths questioned the statement made within the report that recommendations had 'reportedly' been completed and asked that consideration was given to the wording of the statement. Paul Griffiths advised that Members would need to be provided with assurance that if any action had been marked as completed, it had definitely been completed (**added to the action log**).

Paul Griffiths advised that it had been agreed previously that Executive Directors would be invited to the meeting for any actions that were 6 months overdue for completion and advised that this process needed to be strengthened moving forward. Paul Griffiths also added that the tracker process also needed to be simplified.

Members **NOTED** that if a limited assurance rating had been allocated to a report, a follow up review was always undertaken with an independent check carried out of the audit tracker to ensure actions had been completed as stated within the tracker.

Simon Cookson advised that discussions had been held with Robert Williams and more recently with Gwenan Roberts as to whether the UHB could adopt the tracker system used by Internal Audit which could be used for the updating of management responses. Members **NOTED** that this would require the Executive Team to be clear regarding proposed timescales.

Steve Webster advised that further work was required on the process moving forward as there were occasions when the commentary received back on recommendations did not relate to the original recommendation and that some areas marked as in progress could be considered as being complete. Simon Cookson agreed that the process needed to be strengthened from both an Internal Audit and Health Board perspective.

Following discussion, it was **AGREED** that a significant amount of work would need to be undertaken to strengthen and refine the process and Members **NOTED** that a discussion would be held outside of the meeting between Paul Griffiths, Gwenan Roberts and Steve Webster on the process moving forward. Members **NOTED** that a detailed discussion would be held at the April meeting in relation to recommendations which have passed their implementation date by 3 months (**added to the action log**).

Members **RESOLVED** to:

- **NOTE** the report.

PART 3. INTERNAL AUDIT

AC/19/038 **INTERNAL AUDIT PROGRESS REPORT**

Paul Dalton, Head of Internal Audit & Assurance, presented the Internal Audit & Assurance progress report. Since the January 2019 meeting, Members **NOTED** that the following 7 reports had been finalised.

Directorate Review – Primary Care Management Arrangements	**Risk & governance - Reasonable Performance & plan - Substantial Workforce - Reasonable**
Mandatory Training	**Reasonable**
Management of Absence Target	**Reasonable**
Private and Overseas Patients – Follow Up	**Reasonable**
Medical Equipment and Devices	**Limited**
Management of Major Capital – **DRAFT** report	**Limited**
IT Continuity	**Reasonable**

Members **NOTED** that planning was now being undertaken for 2019/20 and that meetings had been held with the Executive Directors to discuss the work programme. Members **NOTED** that the Internal Audit Plan for 2019/20 would be presented to the April Audit Committee for approval. Steve Webster advised that the plan for 2019/20 would need to incorporate Bridgend.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/039 **INTERNAL AUDIT & ASSURANCE AUDIT REPORTS**

Common Issues identified within Directorate Reviews

Paul Dalton presented the report and advised that the report provided a summary analysis of the Directorate reviews undertaken over the last few years and identified the common areas. Paul Dalton advised that it would be helpful if the report could be shared at Directorate level to enable them to consider the content.

Steve Webster suggested that prior to sharing with Directorates, there needed to be a more granular explanation behind each theme which identified what the issues were. Paul Dalton **AGREED** to consider and amend accordingly.

Sara Utley welcomed the report and advised that she found the report helpful and interesting and questioned whether there would be an opportunity to look at best practice being undertaken within Directorates.

Paul Griffiths also welcomed the report and advised that it would be helpful if a process was put into place to enable any lessons learnt from reviews to be shared amongst Directorates (**added to the action log**).

Members **RESOLVED** to:

- **NOTE** the report.

Medical Equipment & Devices – Limited Assurance

John Palmer was in attendance for this item.

Paul Dalton presented the report which had been given a limited assurance rating, with 2 high, 6 medium and 3 low priority recommendations made.

Members **NOTED** that the high priority recommendations related to the updating of the medical equipment register, with recognition made that the system was fairly new. The second high priority recommendation related to staff training on the safe use of equipment. Paul Griffiths expressed concern over the content of the report.

John Palmer advised that he and the Directorate recognised the seriousness of the report and advised that there were two main areas in which the team were focussing on. Members **NOTED** that the risks identified had been included in the risk register and a full and detailed management response had been provided by the Directorate. Members **NOTED** the additional resource would be required to take some of this work forward which would need to be considered as part of the IMTP prioritisation process. Members **NOTED** that focussed discussions would now take place at Clinical Business meetings.

Maria Thomas expressed her concern at the content of the report and that it had been identified that there were 19,000 condemned pieces of equipment which could not be located, with a total purchase price of £10.6m. Members **NOTED** that there were quality issues associated with this matter as this could pose as a risk to patient safety. Maria Thomas advised that this would need to be reported to Quality, Safety & Risk Committee where assurance would need to be provided that processes have been put into place from a Quality & Risk perspective. John Palmer **AGREED** to contextualise the risks within the Directorate exception report.

Maria Thomas sought assurance as to whether there was confidence that systems would improve and that the plan that had been put into place would deliver. John Palmer confirmed that he had confidence that the Directorate would be able to deliver the changes required and would provide support where required.

Steve Webster advised that a significant amount of work would need to be undertaken and expressed concern that some of the recommendations were not clear enough. Steve Webster added that the first step would be to develop a baseline inventory which would require appropriate resourcing.

Dilys Jouvenat expressed concern that items were being purchased from a number of areas and questioned what controls were in place to ensure the inventory was correct. Members **NOTED** that the process in relation to the purchasing of capital equipment was robust and was overseen by the Executive Capital Management Group (ECMG). Members **NOTED** that some further consideration would

need to be given as to whether the process in relation to the leasing of equipment was robust.

Paul Griffiths added that he was very concerned at the non-compliance with regulatory guidelines and questioned whether the UHB was aware of what guidelines needed to be met. Concerns were also raised by Paul Griffiths in relation to equipment being purchased and never used, lack of access to locked medical devices cabinet as a result of the key holder being on leave and the content of the management response, which was very unclear in terms of what actions would be taken and whether the timetable was achievable.

Following discussion, John Palmer accepted the recommendations and **AGREED** to provide an amended management response together with an explanation of how a piece of equipment was purchased and never used (**added to the action log**).

Members **RESOLVED** to:

- **NOTE** the report.

IT Systems – Reasonable Assurance

Paul Dalton presented the report which had been allocated a reasonable assurance rating, with 5 medium and 1 low priority recommendation made.

Members **NOTED** that key findings included the need for an overarching disaster recovery plan for ICT and that further work needed to be undertaken on the reliance of NHS Wales Informatics Service (NWIS) systems.

Members **RESOLVED** to:

- **NOTE** the report.

Directorate Reviews Primary Care Management Arrangements – Reasonable Assurance

Emma Samways presented the report and advised that the review focussed on management arrangements and a report on compliance would be presented to the April meeting.

Members **NOTED** that 3 assurance ratings had been allocated, a reasonable assurance rating had been issued to risk management and governance with 2 medium and 1 low priority recommendation, substantial assurance had been issued to performance and planning with no recommendations made and reasonable assurance issued to

the workforce element, which had 1 high and 5 low priority recommendations.

Members **RESOLVED** to:

- **NOTE** the report.

Mandatory Training – Reasonable Assurance

Emma Samways presented the report which focussed on what processes were in place to ensure level 1 mandatory training compliance was being met. Members **NOTED** that the report had been given a reasonable assurance rating, with 2 high and 3 medium recommendations made.

Members **NOTED** that the review identified that there was a lack of an action plan in place which showed how compliance levels would be achieved and concern was raised in relation to what monitoring was in place for bank and agency staff training compliance.

Members **NOTED** that the report also identified that there was no policy in place for mandatory training which identified the Executive Lead. Members **NOTED** there it had been identified that there was a variation in the approach being taken by Directorates.

Steve Webster questioned the content of the recommendation made in relation to the monitoring of bank and agency staff compliance and requested that the recommendation and action was reviewed and discussed with Joanna Davies to ensure there was clarity on what needed to be tracked.

Members **RESOLVED** to:

- **NOTE** the report.

Management of Absence Target – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating. Members **NOTED** that there were 3 medium recommendations and 1 low recommendation made.

Members **NOTED** that the medium recommendations related to targets and whether an action plan was in place to identify how targets would be met, the need to ensure ward managers were appropriately trained to manage sickness absence and the need to ensure business partner models within each Directorate were consistent. Members **NOTED** that sickness absence monitoring continued to be undertaken at Clinical Business meetings.

Steve Webster questioned the statement made that an action plan was not in place for sickness absence and advised that action plans were in place. Members **NOTED** that at the time of the review Internal Audit did not have sight of any action plans but did identify that a significant amount of work was being undertaken. Maria Thomas expressed concern that an action plan was not in place and **NOTED** that management had accepted the recommendation to develop a plan.

Members **RESOLVED** to:

- **NOTE** the report.

Private & Overseas Patients Follow Up – Reasonable Assurance

Emma Samways presented the report which was a follow up review following the limited assurance report issued in May. Members **NOTED** that a reasonable assurance rating had now been allocated and that out of the 6 original recommendations made, 1 had been fully implemented and significant progress made against the remaining recommendations.

A discussion was held as to whether there were any barriers in place to achieve full implementation.
Members **NOTED** that dedicated resource had not previously been in place and that interviews were being held within the next few weeks for additional resource which would enable key actions to be taken forward.

Members **RESOLVED** to:

- **NOTE** the report.

PART 4. EXTERNAL AUDIT

AC/19/040 **WALES AUDIT OFFICE UPDATE REPORT**

Gareth Lucey presented the report and advised that financial audit planning was now being undertaken for the 2018/19 accounts, which included the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC) accounts.

Members **NOTED** that initial planning meetings had been held and the detailed audit plan would be presented to the Audit Committee meeting in April. Gareth Lucey advised that consideration was being given to the scheduling of work and the pressure being placed on the Finance team during the transition of services from Bridgend.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/041 **WALES AUDIT OFFICE REPORT – ALL WALES REVIEW ON FOLLOW UP OUTPATIENTS NOT BOOKED (FUNB)**

John Palmer was in attendance for this item.

Sara Utley presented the national report which was produced in October 2018 and was based on a review of progress made against the actions identified in a previous review. Members **NOTED** that the report highlighted some areas of improvement and areas that required further work to be undertaken. Members **NOTED** that a response from Welsh Government had been included in the report on national timetables.

John Palmer reminded Members that a number of discussions had been held at the Quality, Safety & Risk and Finance, Performance & Workforce Committees on the progress being made to address the position. John Palmer advised that he had a national role in relation to Outpatients where he would have responsibilities for delivering a response at a national level.

Members **NOTED** that the report identified that the outpatient system was struggling and the FUNB position was increasing at a significant rate. Members **NOTED** that a national workshop had recently been held to discuss the content of the report and that the Wales Audit Office had been asked to provide assistance with contextualising the data.

Members **NOTED** that there would be a national delivery plan for outpatients which had been allocated a financial resource. Members **NOTED** that Board oversight would be need to be driven forward, which would be difficult as a number of data sets would need to be reviewed in order to understand the challenge. Members **NOTED** that a national scorecard had been developed and shared and there would be a need to ensure financially resourced plans were in place across Health Boards.

Maria Thomas welcomed the report and advised that it was helpful that John Palmer was taking the lead at a national level and using Cwm Taf UHB to drive the project forward. Members **NOTED** that future progress would be monitored through the audit tracker.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/042 **WALES AUDIT OFFICE REPORT – ALL WALES REVIEW ON RADIOLOGY SERVICES**

John Palmer was in attendance for this item.

Sara Utley presented the national summary report which concluded that waiting time targets were not being met in radiology services. Members **NOTED** that the report identified that there were recruitment difficulties and IT weaknesses which were putting services under pressure.

John Palmer welcomed the report and advised that the national position reflected the local position, with exception of the issues experienced on sightedness at Boards. Members **NOTED** that CTUHB had been sighted on Radiology Services as a result of the work undertaken on the establishment of the Diagnostic Hub.

Members **NOTED** that the Board was also aware of the Healthcare Inspectorate Wales non-compliance notice received in relation to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the All Wales Radiology Information System (RADIS) compliance was being considered very seriously by the UHB.

Steve Webster questioned why the full report included Health Board data but the report presented here today did not include this information. Sara Utley advised that she was unable to comment as to why this decision had been made as the report was a national report.

Members **RESOLVED** to:

- **NOTE** the report.

AC/19/043 **WALES AUDIT OFFICE REPORT – RECENT PUBLICATION AGENCY STAFF IN WALES**

Sara Utley presented the national report which was accompanied by a short film. Members **NOTED** that in summary the report identified that expenditure had increased, 80% of which was related to ensuring cover was provided for vacant positions.

Paul Griffiths questioned whether a local report was available in addition to the national report. Members **NOTED** that a local report was in the process of being finalised and would be taking into consideration the work being undertaken in relation to the Retinue service.

Sara Utley advised that the Wales Audit Office had also undertaken a review of the work being undertaken by the national group to ensure there was correlation.

Members **RESOLVED** to:

- **NOTE** the report;
- **REFER** the report to the Finance, Performance & Workforce Committee for information.

PART 5. ITEMS FOR INFORMATION

AC/19/044 **COMMITTEE FORWARD WORK PLAN 2018-19**

Members **RECEIVED** and **NOTED** the Forward Work Plan. Paul Griffiths advised that the content of the work plan moving forward would need to be reviewed in light of the Bridgend transition and consideration may need to be given to increasing the frequency of future meetings (**added to the action log**).

Members **NOTED** that Committee Chairs at Cwm Taf UHB and Abertawe Bro Morgannwg UHB had agreed to shadow each other at Committee meetings over the coming weeks.

PART 6. ANY OTHER URGENT BUSINESS

AC/19/045 **ITEMS FOR REFERRAL TO OTHER COMMITTEES**

Members referred the Wales Audit Office report on the recent publication on Agency Staff in Wales to the Finance Performance & Workforce Committee for information.

AC/19/046 **CLOSE OF PART 1 OF THE MEETING – DATE AND TIME OF NEXT MEETING:**

In closing part 1 of the meeting, Members **RESOLVED** that in accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, that representatives of the press and other members of the public are excluded from the second part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

The next meeting of the Committee would be held at 09:00hrs on Monday 1 April 2019.

…….

Paul Griffiths, Chair

Date ……

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 11 FEBRUARY 2019

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
18/028	16/4/ 2018	Audit Recommendations Tracker	Amend Audit tracker template to include specific dates for Director updates and to stipulate that if no progress made within a 3 month period the Director should attend an Audit Committee meeting to explain why limited progress made	May 2018	Interim Board Secretary	**On agenda** Executive Directors are invited to attend the Committee within 3 months.
18/081	09/07/ 2018	Standards of Behaviour Report	Board Secretary to undertake a review of the Declarations of Interests received to ensure all submissions had been captured.	October 2018	Interim Board Secretary	**Update report April 2019**
18/099	8/10/ 2018	JAG Accreditation	Closure report to be presented to a future meeting.	January 2019	Deputy Chief Operating Officer / Interim Board Secretary	**In progress** Confirm when a closure report would be available for the Audit Committee to review. Follow up review following the initial review undertaken in 2017/18.
19/007	14/1/ 2019	Post Payment Verification Progress Report	Consideration to be given to including benchmarking information in future iterations of the report. Reporting process to be amended so that reports are received on progress made year to date and the forward plan for the following year.	April 2019	Post Payment Verification Manager	**April 2019** On agenda

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
19/023	14/1/ 2019	Internal Audit Report – Raising Concerns	Discussion to be held with the Executive Team in relation to introducing a nominated person who would be responsible for receiving any protected disclosures.	February 2019	Director of Workforce and OD / Interim Board Secretary	**In progress** Update to be presented to the April meeting
19/025	14/1/ 2019	WAO Report – Structured Assessment 2018	Discussion to be held with the Executive Team in relation to the content of the management response	February 2019	Interim Board Secretary	**April 2019** On agenda
19/037	11/2/ 2019	Audit Recommendation Tracker	Consideration to be given as to whether the statement made within the report that recommendations had reportedly been completed would need to be reworded. Discussions to be held outside of the meeting as to whether the audit tracker process could be strengthened and refined.	April 2019	Interim Board Secretary	**April 2019** On agenda
19/039	11/2/ 2019	Internal Audit Report – Common Issues Identified within Directorate Reviews	Discussion to be held with the Executive Team in relation to putting a process in place to enable lessons learnt from Directorate reviews to be shared amongst Directorates	April 2019	Interim Board Secretary	**In progress**
19/039	11/2/ 2019	Internal Audit Report – Medical Devices & Equipment	Amended management response to be developed alongside an explanation as to how a piece of equipment was purchased and never used.	April 2019	Chief Operating Officer	**April 2019** On agenda

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT April 2019
19/044	11/2/ 2019	Committee Forward Work Plan	Consideration to be given to the content of the work plan moving forward in light of the Bridgend transition. Consideration to be given to increasing the frequency of future meetings.	April 2019	Interim Board Secretary	**In progress**

Post Payment Verification Progress Report

For the period: 1 April 2018 to 31 March 2019

Cwm Taf University Health Board

Issued:
Prepared by: Mrs Sara Jeremiah (PPV Location Manager)

This document has been prepared for the internal use of Cwm Taf University Health Board.
For any queries or further information relating to this report, please contact Mr Scott Lavender. E-mail: scott.lavender@wales.nhs.uk

1. Introduction

This report has been prepared for the Audit Committee of Cwm Taf University Health Board. The aim of this report is to summarise the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Assembly Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

The purpose of a PPV visit to GMS contractors is to ensure that claims submitted by contractors in respect of GMS Enhanced Services are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and LHBs.

The purpose of a PPV visit to GOS contractors is to ensure that claims submitted by contractors in respect of GOS are correct and in accordance with the relevant NHS General Ophthalmic Services regulations and any specific LHB procedure.

The purpose of a PPV visit to GPS contractors is to ensure that claims submitted by contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific LHB, CPW or WG procedures.

The aim of the PPV process is to ensure propriety of payments of public monies by the LHBs. The probity checks conducted during a PPV visit will provide reasonable assurance to LHBs that public money has been spent appropriately by contractors making accurate claim submissions, contractors internal protocols are clinically sound and services are being claimed for in accordance to clinical specifications.

2. Post Payment Verification process

The PPV department carry out routine visits to all General Practitioner contractors on a three year cycle. During a GMS visit, the PPV department will analyse a sample of 20 claims or 10% of the total number of claims submitted during the year prior to the visit (whichever is the greater) for each enhanced service commissioned to the Practice.

The PPV department carry out routine visits to ophthalmic contractors based on the average number of GOS3 forms submitted during the year. The following table is used in determining the GOS visit schedule in a three year cycle:

Average monthly GOS3 submissions	Number of visits within a three year cycle
Up to 200	1
201 – 400	2
401 – 600	3

During a GOS visit, the PPV department will analyse a sample of 100 claims consisting of GOS1 (Sight tests), GOS3 (Vouchers), GOS4 (Repairs and replacement) and EHEW claims.

The purpose of a GPS PPV audit is to ensure that claims submitted by Pharmacy contractors in respect of GPS are correct and in accordance with the relevant NHS General Pharmaceutical Services regulations and any specific specification set by WG, HB's and CPW.

Following a visit, an initial report is sent to the General Practitioner/ Ophthalmic contractor summarising the observations and findings of the visit and request further information from the contractor to queries that arise from the visit. The contractor is given 28 days to reply to the queries. If no response is received by the contractor, it will be assumed that they are satisfied with the report findings. If the contractor provides feedback, the PPV department will consider this information and assess if it clarifies the queries.

Taking the above into account, the report is finalised with recommended recoveries (If appropriate) and sent to the UHB Finance and Primary Care lead for approval.

If the report is approved, the PPV team will instruct the Payments department within NWSSP Primary Care Services to make the recovery against the contractor.

Where the PPV team identify a high number of claim errors for a particular service (10% for GMS, GOS & GPS), a recommendation will be made to the UHB that a more substantive review of the service needs to be carried out. If this is the case, the PPV team will carry out a revisit to the contractor within one year of the routine visit. During this visit all claims submitted by the contractor for the identified services only will be analysed for the period between the last visit and the routine visit date, usually three years.

In addition to carrying out visits, the PPV team continually monitor claims submitted by GMS, GOS and GPS contractors to assist in the identification of trends and outliers. This information is used to assist in the preparation of visit samples and also to alert the UHB and Local Counter Fraud Specialist if suspicious claiming patterns emerge.

The PPV team are also available to provide advice, support and guidance to contractors and UHBs when required.

3. Summary of findings and observations

General Medical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
19	10	9	19	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 19 GMS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £6,312.87 from completed visits to GMS contractors in the UHB area due to errors identified in contractor's enhanced service claims. Recoveries are also to be made from on-going visits. These recoveries have not been included in the above total as they have not been authorised by the UHB. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 2.28% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

General Ophthalmic Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
12	10	2	12	0

During the period 1st April 2018 to 31st March 2019, the PPV team have visited 12 GOS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £2,769.95 from completed visits to GOS contractors in the UHB area due to errors identified in contractors' GOS claims. A summary of the GOS visits can be found in appendix three of this report.

The overall claim error rate for the locality was 3.66% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in appendix four of this report.

General Pharmaceutical Services

Planned visits for UHB	Completed visits	Visits on-going	Total visits carried out	Variance
26	20	6	26	0

During the period 1st April 2018 to 31st March 2019, the PPV team has visited 26 GPS contractors as per the visit plan agreed with the UHB. The PPV team have recovered £280.00 from completed visits to GPS contractors in the UHB area due to errors identified in contractor's Medical Review Use claims. A summary of the GPS visits can be found in **Appendix 5** of this report.

The overall claim error rate for the Health Board was 0.66% from all claims sampled.

A summary of the PPV teams findings from visits by service can be found in **Appendix 5** of this report with a graphical representation of the error rates by service can be found in **Appendix 6**

4. Conclusions and recommendations

The PPV team have been working hard to develop and enhance relationships with contractors, Primary Care and Governing bodies to ensure we are delivering a service that is of the highest possible standard. As part of this, a training event for Ophthalmic contractors is going to be arranged where Scott Lavender will conduct a presentation to explain the PPV process and the requirements on the contractors when they are completing patient records.

New protocols have been written that accurately reflect our processes after a year of streamlining and changes. This has been quite a fruitful exercise as it has further enhanced networking and relationships for our department.

We are offering one to one training sessions with contractors where they make the request, as we feel it would have a greater benefit long term and provide further assurance that we are taking the education and training aspect of our roles seriously.

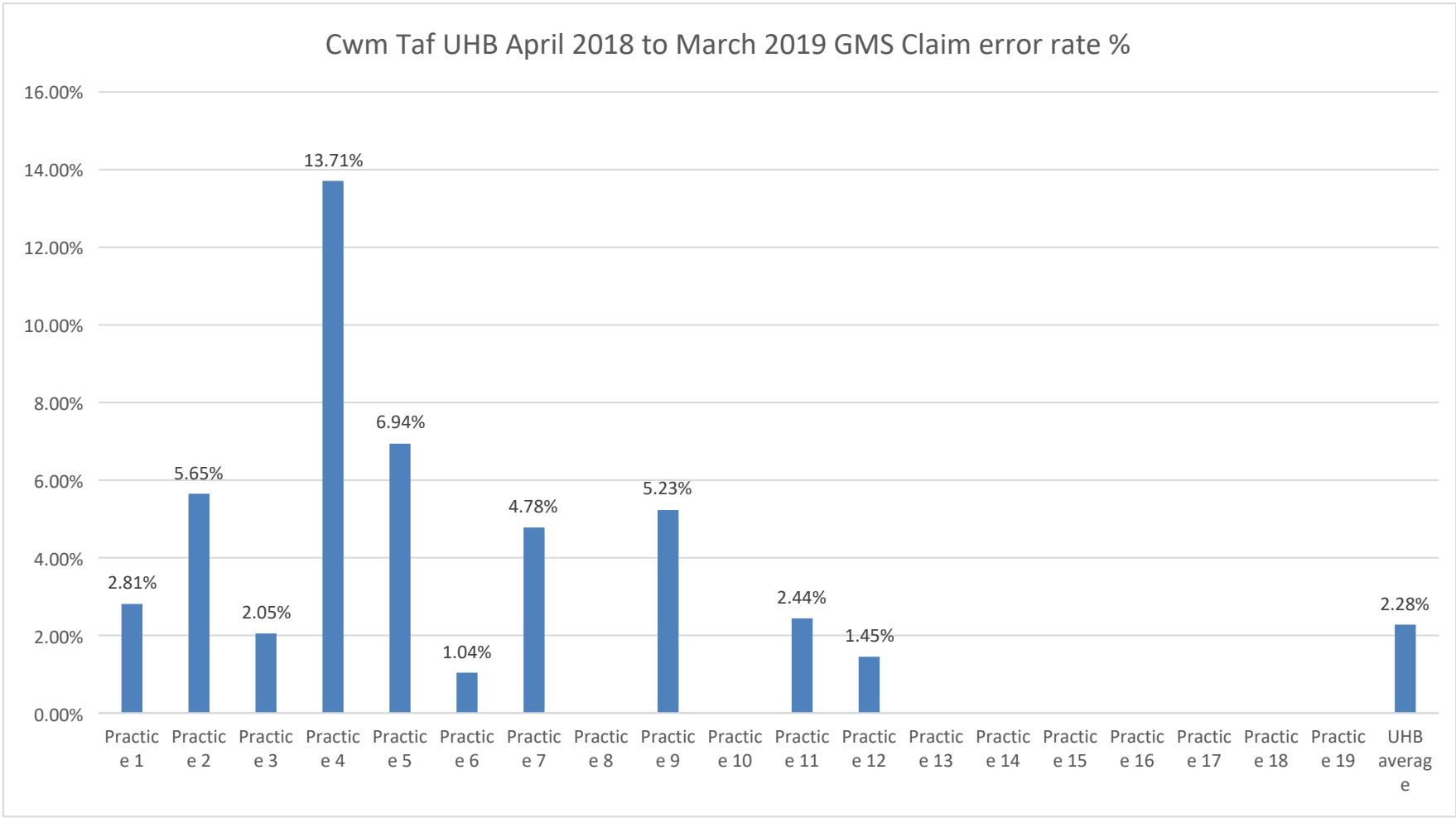
The PPV team will continue to assist the UHB in providing training, advice or informally meeting with contractors or their staff to discuss PPV related issues.

Cwm Taf University Health Board
GMS PPV Progress Report: 2018/2019

Completed GMS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	178	5	3.93%	2.81%	£207.90	1 x Anti-coagulation monitoring, 1 x DOAR and 3 x Near Patient Testing
Practice 2	Routine	230	13	0.00%	5.65%	£943.77	1 x Administration of Gonadorelins, 2 x Anti-coagulation monitoring, 3 x Denosumab, 5 x DOAC and 2 x Minor surgery
Practice 3	Routine	195	4	1.03%	2.05%	£498.34	3 x Care Homes and 1 x Administration of Gonadorelins
Practice 4	Routine	350	48	7.43%	13.71%	£1,807.76	1 x Anti-coagulation monitoring, 20 x Anti-coagulation monitoring DOM, 1 x Contraceptive services, 3 x DOAC/DOAR, 15 x Drug Misuse, 2 x Minor surgery, 3 x Near Patient Testing and 3 x Pertussis
Practice 5	Routine	173	12	1.73%	6.94%	£822.75	11 x Minor surgery and 1 x DOAC
Practice 6	Routine	383	4	1.57%	1.04%	£112.91	2 x Near Patient Testing, 1 x Minir Surgery & 1 x Contraceptives
Practice 7	Revisit	627	30	0.32%	4.78%	£757.20	20 x Near Patient Testing, 8 x Care Homes & 2 x MMR Catch-up
Practice 8	Revisit	1060					File in progress, initial report sent to practice
Practice 9	Routine	172	9	13.37%	5.23%	£660.87	1 x Anti-coagulation monitoring, 1 x Contraceptive services and 7 x Minor surgery
Practice 10	Routine	337					File in progress, initial report sent to practice

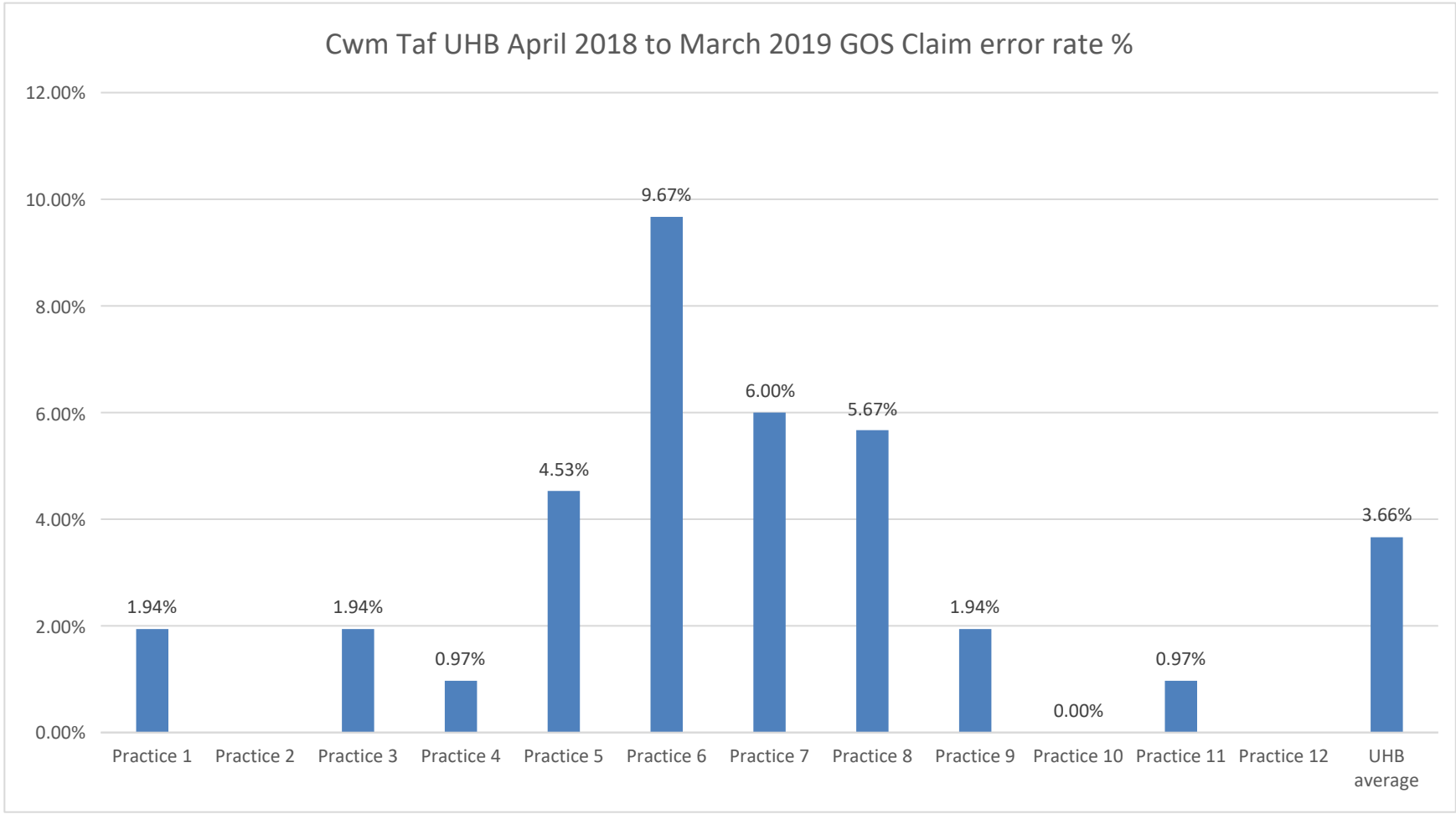
Practice 11	Routine	205	5	3.41%	2.44%	£298.87	2 x Minor surgery, 1 x Contraceptive services, 1 x Pertussis and 1 x Near Patient Testing
Practice 12	Routine	276	4	1.45%	1.45%	£202.50	1 x Anti-coagulation monitoring, 2 x Care homes and 1 x DOAC/DOAR
Practice 13	Revisit						File in progress, visit in progress
Practice 14	Revisit	13					File in progress, awaiting response from UHB
Practice 15	Revisit	40					File in progress, initial report sent to practice
Practice 16	Revisit	864					File in progress, initial report sent to practice
Practice 17	Routine	181					File in progress, initial report sent to practice
Practice 18	Revisit	599					File in progress, awaiting Response from UHB
Practice 19	Routine						Visit scheduled for 21/03/2019
UHB average		**5,883**	**134**		**2.28%**	**£6,312.87**	


Cwm Taf UHB April 2018 to March 2019 GMS Claim error rate %
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
2.81%
5.65%
2.05%
13.71%
6.94%
1.04%
4.78%
5.23%
2.44%
1.45%
2.28%
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Practice 7
Practice 8
Practice 9
Practice 10
Practice 11
Practice 12
Practice 13
Practice 14
Practice 15
Practice 16
Practice 17
Practice 18
Practice 19
UHB average

Cwm Taf University Health Board
GOS PPV Progress Report: 2018/2019

Completed GOS visits

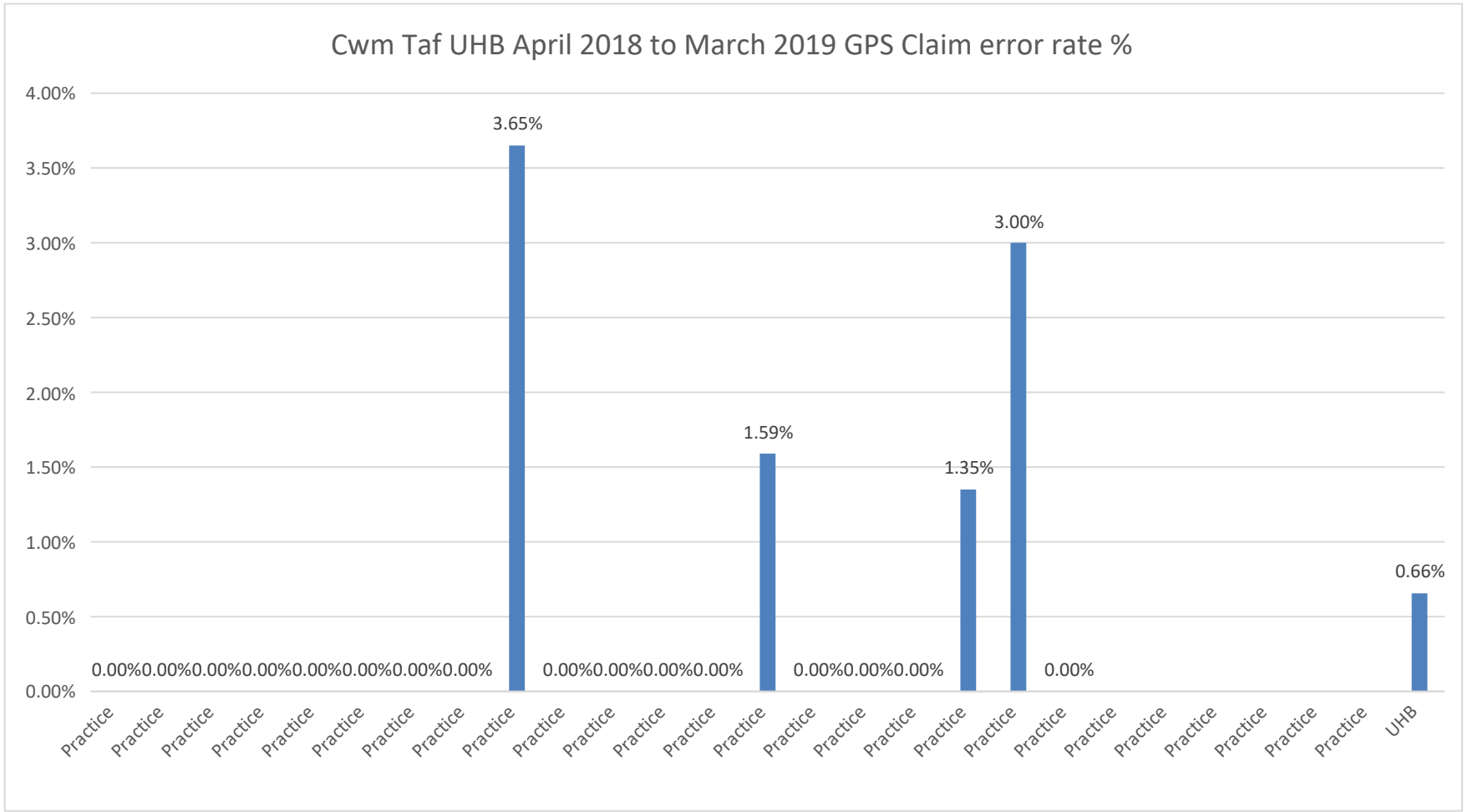
Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	103	3	4.00%	1.94%	£63.70	1 x Tint on GOS 3 and 2 x GOS 4
Practice 2	Revisit	300					File in progress, initial report sent to practice
Practice 3	Routine	103	2	16.50%	1.94%	£80.80	2 x EHEW
Practice 4	Routine	103	1	8.74%	0.97%	£68.10	1 x GOS 3
Practice 5	Revisit	300	12	1.33%	4.53%	£523.40	12 x EHEW
Practice 6	Revisit	300	29	32.66%	9.67%	£1,084.20	29 x EHEW
Practice 7	Routine	100	6	33.00%	6.00%	£198.10	3 x GOS 4 and 3 x EHEW
Practice 8	Revisit	300	17	40.33%	5.67%	£631.95	8 x GOS 4 and 9 x EHEW
Practice 9	Routine	103	3	26.21%	1.94%	£99.50	1 x GOS 3 and 2 x EHEW
Practice 10	Routine	103	0	18.00%	0.00%	None	All claims were verified
Practice 11	Routine	103	1	21.36%	0.97%	£20.20	1 x EHEW
Practice 12	Routine	103					File in progress, initial report sent to practice
UHB average		**2,021**	**74**		**3.66%**	**£2,769.95**	


Cwm Taf UHB April 2018 to March 2019 GOS Claim error rate %
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
1.94%
1.94%
0.97%
4.53%
9.67%
6.00%
5.67%
1.94%
0.00%
0.97%
3.66%
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Practice 7
Practice 8
Practice 9
Practice 10
Practice 11
Practice 12
UHB average

Cwm Taf University Health Board
GPS PPV Progress Report: 2018/2019

Completed GPS visits

Practice Name	Visit Status	Sample Size (numeric)	Claim errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Practice 1	Routine	2	0	5.00%	0.00%	£0.00	All claims were verified
Practice 2	Routine	52	0	3.85%	0.00%	£0.00	All claims were verified
Practice 3	Routine	100	0	2.00%	0.00%	£0.00	All claims were verified
Practice 4	Routine	76	0	0.00%	0.00%	£0.00	All claims were verified
Practice 5	Routine	90	0	8.91%	0.00%	£0.00	All claims were verified
Practice 6	Routine	100	0	1.00%	0.00%	£0.00	All claims were verified
Practice 7	Routine	20	0	25.00%	0.00%	£0.00	All claims were verified
Practice 8	Routine	30	0	0.00%	0.00%	£0.00	All claims were verified
Practice 9	Revisit	137	5	36.50%	3.65%	£140.00	5 x MUR
Practice 10	Routine	93	0	0.00%	0.00%	£0.00	All claims were verified
Practice 11	Routine	100	0	2.00%	0.00%	£0.00	All claims were verified
Practice 12	Routine	100	0	21.00%	0.00%	£0.00	All claims were verified
Practice 13	Routine	96	0	5.21%	0.00%	£0.00	All claims were verified
Practice 14	Routine	63	1	1.59%	1.59%	£28.00	1 x MUR
Practice 15	Routine	85	0	18.77%	0.00%	£0.00	All claims were verified
Practice 16	Revisit	30	0	3.33%	0.00%	£0.00	All claims were verified
Practice 17	Routine	97	0	0.00%	0.00%	£0.00	All claims were verified
Practice 18	Routine	74	1	24.32%	1.35%	£28.00	1 x MUR
Practice 19	Routine	100	3	6.00%	3.00%	£84.00	3 x MUR
Practice 20	Routine	80	0	0.00%	0.00%	£0.00	All claims were verified
Practice 21	Routine						Visit scheduled for 12/03/2019
Practice 22	Routine						Visit scheduled for 26/03/2019
Practice 23	Routine						Visit scheduled for 14/03/2019
Practice 24	Routine						File in progress, visit undertaken
Practice 25	Routine						Visit scheduled for 14/03/2019
Practice 26	Routine						Visit scheduled for 26/03/2019
UHB average		**1,525**	**10**		**0.66%**	**£280.00**	


Cwm Taf UHB April 2018 to March 2019 GPS Claim error rate %
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
3.65%
3.00%
1.59%
1.35%
0.66%
0.00%0.00%0.00%0.00%0.00%0.00%0.00%0.00%
0.00%0.00%0.00%0.00%
0.00%0.00%0.00%
0.00%
Practice
UHB

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.2** **1 April 2019**

Audit Committee Report
AUDIT RECOMMENDATIONS TRACKER

Executive Lead: Board Secretary / Director of Corporate Services
Author: Interim Board Secretary
Contact Details for further information: Gwenan.roberts@wales.nhs.uk

Purpose of the Audit Committee Report
To update the Audit Committee on reported progress with implementation of Audit report recommendations.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2018-2021, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Supporting evidence	• Wales Audit Office (WAO) Reports • Internal Audit Reports

Engagement – Who has been involved in this work?
Executive Director and Officer leads for each of the Wales Audit Office (WAO) and Internal Audit (IA) reports have been involved in providing updates on progress where appropriate.

Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Audit Committee is asked to: • **DISCUSS** and **NOTE** the contents of the report; and • **ENDORSE** the progress made to date and agree any related further actions, particularly relating to the High Risk recommendations, where action has been significantly delayed beyond originally intended completion dates.						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	No impact
Legal implications	There may be an adverse effect on the organisation if the UHB does not fully implement learning and improvements identified as part of Audit arrangements.
Population Health	Ensuring a robust governance framework as documented and supported by Audit review will have a positive impact on the population that we serve.
Quality, Safety & Patient Experience	Robust internal processes aligned with a strong governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality.
Resources	Many of the Audit reviews assess the strength of internal control. Failure to ensure recommended actions are implemented could adversely impact on the organisation's resources.
Risks and Assurance	The related risks and assurance implications are captured within individual audits and feature within the related recommendations. The development of this system of tracking progress with implementation of recommendations is a mitigating action to ensure recommendations from Internal Audit reviews are implemented.
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. Link to Health & Care Standards Welsh Government web site The work reported in this summary and related annexes take into account many of the related quality themes.
Workforce	No impact
Freedom of Information Status	Open

AUDIT RECOMMENDATIONS TRACKER

1. SITUATION / PURPOSE OF REPORT

The main purpose of this report is to present an update to the Audit Committee on reported progress with implementation of Audit report recommendations. This report relates to both internal and external audit review recommendations.

2. BACKGROUND / INTRODUCTION

Ensuring the organisation learns from and implements recommendations arising from Audit reports is an essential component of a strong organisational governance framework.

Tracking progress with implementation of Audit recommendations against agreed timescales is also an important assurance tool to support the work of the Committee and to provide assurance into the Board.

It is also important to consider why implementation of some recommendations has been delayed against the original agreed timescales and management response.

The attached summary table and supporting documents (Internal Audit Reports at **Appendix 1**) make reference to:

- 18 of the 60 Internal Audit reports received by the Audit Committee since April 2017,
- 4 of the 24 Wales Audit Office reports received since January 2014 (including National reports).

A judgement on completion / partial completion has been made where progress is reported in this way.

Of the 60 Internal Audit report updates summarised and included in this report Members should **NOTE** that:

- 334 recommendations have been made;
- 287 recommendations have been reportedly implemented, although it is important to recognise that some of these require ongoing action
- 48 recommendations are outstanding, and of these
  - 23 are overdue their original date for implementation (although a number are partially implemented or related work is progressing). Of these, there are five 'High Risk' rated recommendations.

Progress with reported completion of recommendations continues to improve and this update report focuses on the 'overdue' or ongoing recommendations reported as outstanding within the updates sought from the lead Directors or their management teams. A summary of updated actions against outstanding recommendations is attached as **Appendix 1a**.

Of the 24 Wales Audit Office reports (External Audit **Appendix 2**) within the Audit Tracker:

- 194 recommendations have been made
- 167 recommendations have reportedly been implemented, although it is important to note that some of these require ongoing action
- 27 recommendations are outstanding with 13 overdue their originally agreed completion date and relate mainly to Follow Up Outpatients Not Booked (FUNB)), Discharge Planning and the 2017 Structured Assessment, although it is important to note that some actions have taken place to progress implementation whilst some remain ongoing. Members will note the close and ongoing scrutiny at Finance, Performance & Workforce Committee and Quality, Safety & Risk Committee on actions to address the issues associated with FUNB.
- Members will be aware that the management responses to the 2018 Structured Assessment will be discussed as an agenda item at the Audit Committee.

A summary of updated actions against outstanding recommendations is attached at **Appendix 2a**.

Members should **NOTE** that follow up outpatients not booked has been discussed in detail at the Quality, Safety & Risk Committee in March 2019 and also at the Finance, Performance & Workforce Committee in February 2019.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Where there are actions outstanding within the tracker log, the related updates are referenced below for consideration of the Audit Committee. The Audit Committee has agreed that where high and / or medium risk related recommended actions fall outside a 3 or 6 months timescale, the lead Director (s) will be asked to present an update on the related reasons for the slippage in timescales and intended action to address the recommendation to the Committee.

Members may wish to consider the outstanding recommendations and their related timescales, particularly with high and / or medium risk rated recommendations, and arrange for the lead Director to attend the next Audit Committee meeting in order for Members to be updated on related progress / intended actions.

4. RECOMMENDATION

Members of the Audit Committee are asked to**:**

- **DISCUSS** and **NOTE** this update report and the attached summary of progress
- **ENDORSE** the progress made to date and agree any related further actions, particularly relating to the High Risk recommendations, where action has been significantly delayed beyond originally intended completion dates.

Freedom of Information Status	Open

Appendix 1

Summary of Outstanding Internal Audit Recommendations (March 2019)

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Corporate Legislative Compliance	Board Secretary / Director of Corporate Services & Governance	Reasonable	Jul-16	Jul-16	4	3	1	0	1
Complaints Management - Follow Up	Director of Nursing, Midwifery & Patient Services	Reasonable	Jan-17	Feb-17	7	6	1	0	1
Clinical Coding	Director of Planning & Performance	Limited	May-17	May-17	5	5	0	0	0
Corporate Risk Management	Director of Corporate Services & Governance	Reasonable	May-17	May-17	6	6	0	0	0
Mental Health Act Aftercare	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	7	7	0	0	0
Electronic Discharge Advice Letter (EDAL)	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	5	5	0	0	0
Financial Systems	Director of Finance	Reasonable	May-17	May-17	3	3	0	0	0
Occupational Health	Director of Workforce & OD	Reasonable	May-17	May-17	9	9	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
IT (Maternity Information Systems)	Director of Primary, Community & Mental Health	Reasonable	May-17	May-17	6	6	0	0	0
Recruitment Vacancy Management	Director of Workforce & OD	Reasonable	May-17	May-17	4	4	0	0	0
Public Sector Prompt Payment	Director of Finance	Substantial	May-17	May-17	2	2	0	0	0
DOLS Follow Up	Director of Nursing, Midwifery & Patient Services	Substantial	May-17	May-17	5	5	0	0	0
Recruitment	Director of Workforce & OD	Reasonable	Sep-17	Sep-17	4	4	0	0	0
Environmental Sustainability	Chief Operating Officer	Reasonable	Sep-17	Sep-17	3	3	0	0	0
Health and Care Standards	Director of Nursing, Midwifery & Patient Services	Substantial	Sep-17	Sep-17	1	1	0	0	0
Paeds, Obs, Neonates Capital Scheme PCH	Director of Planning & Performance	Reasonable	Sep-17	Sep-17	10	10	0	0	0
Patient Property & Monies	Director of Nursing, Midwifery & Patient Services	Reasonable	Sep-17	Sep-17	8	8	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Safeguarding	Director of Nursing, Midwifery & Patient Services	Reasonable	Sep-17	Sep-17	4	4	0	0	0
Directorate Governance - Pathology	Chief Operating Officer	Reasonable	Sep-17	Sep-17	8	8	0	0	0
Directorate Governance - Medicines Management	Director of Primary, Community & Mental Health	Reasonable	Sep-17	Sep-17	7	7	0	0	0
Directorate Governance - Acute Medicine and A&E (Follow Up)	Chief Operating Officer	Reasonable	Sep-17	Sep-17	12	12	0	0	0
Carbon Reduction	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	3	3	0	0	0
Data Quality Monitoring	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	5	5	0	0	0
Clinical Coding (Follow Up)	Director of Planning & Performance	Reasonable	Oct-17	Nov-17	5	5	0	0	0
Safety Bulletin Alerts	Director of Corporate Services & Governance	Reasonable	Oct-17	Nov-17	3	3	0	0	0
Nurse Staff Revalidation	Director of Nursing, Midwifery & Patient Services	Substantial	Oct-17	Nov-17	2	2	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
CAMHS Data Quality	Director of Primary, Community & Mental Health	Reasonable	Nov-17	Nov-17	5	5	0	0	0
JAG Accreditation Endoscopy **(See Follow Up review below)**	Chief Operating Officer	Limited	Dec 17	Jan 18	(was 7)	-	-	-	-
Clinical Audit	Director of Nursing, Midwifery & Patient Services	Reasonable	Dec 17	Jan 18	4	4	0	0	0
Risk Management	Medical Director	Reasonable	April 18	April 18	5	5	0	0	0
Performance Management	Deputy Chief Executive/Director of Planning & Performance	Limited	Mar 18	April 18	8	8	0	0	0
Governance Arrangements Hosted Bodies	Director of Corporate Services & Governance/ Board Secretary	Reasonable	April 18	April 18	3	3	0	0	0
IM&T Strategy	Chief Operating Officer	Reasonable	Mar 18	April 18	7	7	0	0	0
Core Financial Systems	Director of Finance	Substantial	Feb 18	April 18	2	2	0	0	0
Scheme of Delegation Review	Director of Finance	Reasonable	Feb 18	April 18	3	3	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Health Roster Review	Director of Workforce & OD	Reasonable	April 18	May 18	6	6	0	0	0
Private & Overseas Patients	Director of Finance	Limited	May 18	May 2018	6	4	2	0	2
EASC Commissioning	Chief Ambulance Services Commissioner	Reasonable	April 18	May 18	1	1	0	0	0
Fire Management	Director of Corporate Services & Governance/ Board Secretary	Reasonable	May 18	May 18	7	4	3	0	3
Governance Arrangements with Local Authorities & Third Sector Partners	Deputy Chief Executive/Director of Planning & Performance	Reasonable	May 18	May 18	5	5	0	0	0
ACT Management Arrangements	Interim Chief Operating Officer	Reasonable	July 18	July 18	16	15	1	0	1
ACT Compliance	Interim Chief Operating Officer	Reasonable	July 18	July 18	5	5	0	0	0
Healthcare Standards	Director of Nursing	Reasonable	July 18	July 18	3	3	0	0	0
Annual Quality Statement	Director of Nursing	Reasonable	July 18	July 18	2	2	0	0	0

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
JAG Accreditation Endoscopy follow up	Chief Operating Officer	Reasonable	Sept18	July 18	11	9	2	0	2
General Data Protection Regulation	Board Secretary	Reasonable	Sept 18	Oct 18	8	7	1	0	1
Performance Management Monitoring and Reporting follow up	Deputy Chief Executive / Director of Planning and Performance	Reasonable	Aug 18	Oct 18	8	6	2	0	2
CRC Energy Efficiency	Deputy Chief Executive / Director of Planning and Performance	Substantial	Jul 18	Oct 18	3	3	0	0	0
Governance Arrangements Primary and Community Care Committee	Director of Corporate Services and Governance / Board Secretary	Substantial	Aug 18	Oct 18	4	1	3	0	3
Facilities Compliance	Chief Operating Officer	Reasonable	Sept18	Oct 18	2	2	0	0	0
Facilities Management	Chief Operating Officer	Reasonable	Sept18	Oct 18	15	14	1	0	1
Retention of Staff	Director of Workforce and OD	Limited	July 18	Jan 19	6	6	0	0	0
Raising Concerns	Director of Workforce and OD / Board Secretary	Limited	Oct 18	Jan 19	7	6	1 (partial)	0	1 (partial)

Report Title	Director Lead	Assurance Rating	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Future Generations and Well-being Act	Director of Public Health	Reasonable	Aug 18	Jan19	4	1	3	3	0
Continuing Healthcare	Director of Nursing Midwifery and Patient Care	Reasonable	Oct 18	Jan19	5	2	3	1	2
Medical Devices and Equipment	Chief Operating Officer	Limited	Feb 19	Feb 19	11	1	10	7	3
IT Systems	Chief Operating Officer	Reasonable	Feb 19	Feb 19	6	1	6	5	0
Primary Care Management Arrangements	Director of Primary, Community & Mental Health Services	Reasonable	Feb 19	Feb 19	9	5	4	4	0
Mandatory Training	Director of Workforce & OD	Reasonable	Feb 19	Feb 19	5	1	4	4	0
Absence Management	Director of Workforce & OD	Reasonable	Feb 19	Feb 19	4	4	0	0	0
Totals					**334**	**287**	**48**	**24**	**23**

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Corporate Legislative compliance	The Health Board will firstly complete a risk assessment of all corporate legislative requirements and then maintain a tracker for those identified as high risk.	Medium	Board Secretary	Head of Corporate Services	November 2018 Betsi Cadwaladr Health Board presented to Board Secretaries a comprehensive approach to corporate legislative requirements - this system will be shared in due course across Wales and will provide an All Wales approach. March 2019 – awaiting progress to share system, being actively pursued.	In progress – should be available in 2019
Complaints Management - Follow Up	Management should review the current procedures for completing responses to ensure that they are being consistently completed by the most appropriate staff in order to minimise any delays whilst ensuring a high quality response.	Medium	Director of Nursing Midwifery and Patient Services	Heads of Nursing / Team Manager Complaints / Senior Manager for Investigations & QI	March 2019 remains in progress timescales not yet as desired	In progress Awaiting agreement of funding as part of IMTP.
Private & Overseas Patients	a) Following the development of procedures for overseas patients, the Health Board should ensure that all relevant staff are made aware of the need to identify those patients that are potentially from overseas. b) Management should ensure that those staff who are more likely to encounter overseas patients should have appropriate training and awareness incorporated into their induction process.	High	Director of Finance/Chief Operating Officer/Director of Planning & Performance	Directorate Manager & Head of Medical Records	March 2019 update – Overseas Officer post has now been appointed to and would be commencing on 1 April 2019.	In progress
	a) Management should produce documentation for members of the public that provides information on their rights and responsibilities as an overseas patient and the expectations that will be placed upon them in order to determine eligibility for free health care provision. b) Information relating to potential charges that an overseas patient may incur should be made publically available.	Medium	Director of Finance/Chief Operating Officer/Director of Planning & Performance	a) Directorate Manager & Head of Medical Records b) Head of Financial Planning	a) Agreed. This will be actioned with support from the Commissioning and Communication teams. b) Agreed Sept 2018 update - Documentation located on DOH website. This will be circulated and put up in patient areas once Overseas Manager in post. March 2019 Update - Overseas Officer recruited and due to commence 1 April 2019. The posters located on DOH are no longer available, the only information sheets were relating to EHIC cards. Weekly teleconference meetings with the Welsh Government being held in the run up to 29 March 2019 to keep updated on the latest discussions with UK Government regarding cross border and reciprocal healthcare arrangements post Brexit.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	c) Information relating to potential charges that a private patient may incur should be made publically available.				The Central Legislation Support Team (CLST) is currently updating the Reciprocal Healthcare Legislative Changes summary paper to include potential scenarios for OVMs. In view of this, no poster/leaflets to be circulated at the current time. They are planning to circulate the Reciprocal Health Legislative Changes summary paper with LHB CEOs and for wider NHS Wales signposting when finalised. The CLST is planning to compile central notice/lines to take for OVMs to adapt locally and use on their websites. Notice to potentially include scenarios, link to UK Government list of countries with reciprocal agreements and with effect from dates of changes. c) Private Patients are provided with details of the charges made by the Health Board for their 'hotel services costs' prior to their admission. It is important to note that the Health Board does not charge for any clinical staff costs etc., as these are charged directly by the clinician concerned. *Audit comment: While we note the management response to recommendation 'c', at the time of the audit fieldwork we were not aware of the details of charges provided to private patients prior to their admission. We consider this process appropriate to address the recommendation.*	
Fire Management	Opportunities will be explored to better capture information, including developing the NWSSP: SES database and improve reporting from Divisions and Directorates. (D)	High	Director of Corporate Services & Governance/Board Secretary	Head of Operational Health, Safety & Fire Director of Corporate Services & Governance	Agreed. The key issue is the absence of meaningful management information and the limitations of a national software system, which results in workarounds being developed. Significant effort is made to ensure that the fire risk assessments are completed adequately; however, the 'Fire Auditing and Reporting System' cannot provide accurate/ up-to-date information for discussion with directorate managers. Noting the limitations of the national system, there are a number of local systems in place as a workaround, however this results in duplication. In the first instance, the issue will be raised with NWSSP: SES to request improvement of the national system, and advise on what action can be taken nationally to address this concern.	Ongoing The limitations of the national system have been raised but the matter is not in the control of the UHB.
	Updated DSEAR reviews will be conducted in accordance with HSE requirements. (O)	Medium	Director of Corporate Services & Governance/Board Secretary	Head of Health, Safety & Fire	Update December 2018 - Capital monies have now been allocated for this work and tenders are being prepared.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Fire folders be reviewed on a regular basis and out of date information removed and updated.(O)	Low	Director of Corporate Services & Governance/Board Secretary	Fire Safety Manager	Update December 2018 - The Audit of the 400+ Fire folders across the UHB was commenced in 12/18 and is due for completion 03/19.	In progress. Audits will commence in Autumn 2018 - Now due for completion in March 2019
ACT Management Arrangements	The directorate should ensure that all staff required to complete DoI do so in a timely manner. The Health Board should ensure that the Standards of Behaviour Policy is updated to reflect the amendments agreed at the September 2017 Audit Committee in relation to the requirement for Nil Returns and returns for staff Band 8 and above to make returns. The Health Board should review the policy and clarify how directorate / line managers are made aware of the declarations made by their staff. A report provided to directorate managers of returns made and nil returns, would allow due consideration to be given to declarations and would also allow directorate managers to chase those staff who have failed to make a return.	Medium	Chief Operating Officer	Directorate Manager/Services Leads/Head of Corporate Services/Board Secretary	January 2019 Standards of Behaviour Policy updated. Corporate Team working on an automated process to take place in March 2019 for all Declarations of Interest and provide directorate level reports during May 2019	Ongoing
JAG Accreditation Endoscopy - Follow Up	Approval of the Terms of Reference for the JAG working group should be documented to ensure it has been approved by an appropriate group or committee.	Low	Chief Operating Officer	Senior Nurse Medical Specialities	Update December 2018 - Terms of Reference now being reviewed and will be submitted to the Endoscopy Steering Group for approval.	In progress
	Management should ensure that a project plan is in place that incorporates all the actions that are required to meet the JAG accreditation status by a required date.	High	Chief Operating Officer	Demand and Capacity, waiting times management – Ruth Morrissey, continual.	There has been significant progress made on the timeliness of delivery of the service over the last year, not just in preparation for an improved position for JAG accreditation but to improve the quality of service for our patients. In addition, there has also been the development of a delivery plan for each site for JAG accreditation which is a live document for each site that is maintained via each JAG accreditation meeting.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Each action identified should include reference to the domains and standards that it refers to, an identified lead, and the timescale for completion.			JAG accreditation plan - Neil Hawkes & Carolyn John, in place and being used.	Within the plan each domain and progress is clearly shown. These plans will be used as the foundation for each JAG accreditation meeting. It will be used to focus the agenda and report progress. December 2018 update - Work in this area continues and is ongoing	
	Review by the relevant consultants of the supporting appendices to the Operational Policy should be completed as soon as practically possible to allow for final approval of the Operational Policy.	Low	Chief Operating Officer	Consultant Gastroenterologist	December 2018 update - Diabetes guidelines received, for final approval & sign off in January 2019 ESG meeting.	In progress January 2019
GDPR	An assessment of the departments included on the IAR should be undertaken to identify those who have not completed the IAR exercise. As part of this a timetable for all departments to have submitted entries should be set out.	Low	Board Secretary	Information Governance/Data Protection Officer	This is difficult to collate due to the way that the REDCap system is set up. However, the IG team will export into excel and filter to review potential gaps. December 2018 update - Work has commenced in this area although has not yet been fully completed - this will be undertaken by the end of February 2019 March 2019 Further work has been undertaken whereby asset owners have been issued with a system reminder to populate the second element of their assets. Work is ongoing to migrate Redcap into SharePoint to align with the system used within the Bridgend hospital site.	Part completed
Performance management monitoring and reporting follow up	**Updated Recommendation**. Management should continue to review the levels of support provided to directorates to ensure demand and capacity planning is embedded within their working environment. We note the need to analyse and manage the resource implications of the merger with Bridgend on the current demand and capacity work, to ensure the progress that has been made continues.	Medium	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	**Updated Management Response**. This is an ongoing challenge, with renewed efforts being made to recruit skilled individuals to join the Directorate, in parallel with the development and retention of existing analytical staff. The demand and capacity work related to Bridgend will be integrated into the Cwm Taf led IMTP process for 2019/20. The demand and capacity work will therefore be led by Cwm Taf, but supported by ABMU staff who currently hold the data. The Directorate is fully engaged in the Transition Programme to ensure the appropriate level of resource transfer for April 1st 2019.	Ongoing. Recruitment and retention of key staff remains a key challenge, with a further recruitment drive underway.
	Updated Recommendation - The Health Board should consider whether phasing of demand and capacity plans would be beneficial in terms of providing a more co-ordinated planning approach.	Low	Deputy Chief Executive/Directorate of Planning & Performance	Assistant Director of Performance & Information	The next iteration of the plans will look to incorporate a way of dynamically updating the assessment every month. Whilst the phasing suggested is sensible, the time constraints associated with dedicating analytical resource to coincide with the IMTP process may not facilitate such a change to the current process.	Ongoing. This remains a medium term objective for the P&I directorate.

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
					The regular updating of demand and capacity plans in a dynamic way will be the UHB approach to phasing, which will highlight changes in any one Directorate that other Directorates will be able to take account of in their planning.	
Governance arrangements primary and community care committee	The Committee should ensure that training and development requirements are documented in the Terms of Reference to satisfy the requirements of the Health Board's Standing Orders.	Low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders.	TOR updated – to be agreed with Chair - for ratification at the April meeting
	The Primary & Community Care Committee should clarify in their Terms of Reference the required Members to be present at each meeting.	Low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders and will include specifically the requirement for executive directors to be present. The TOR will also be amended to clarify that the Chair is included in the number of Independent Members at the meeting.	TOR updated – to be agreed with Chair - for ratification at the April meeting
	The Committee should review the Terms of Reference to correct any duplications of responsibilities and text.	low	Board Secretary	Head of Corporate Services	Following discussion with the Committee Chair, the Terms of Reference will be amended in line with Standing Orders and to correct the duplication of responsibilities and text.	TOR updated – to be agreed with Chair - for ratification at the April meeting
Facilities management	The review of the historical roster templates that are being used should be progressed with revised rosters realigned to meet the current demands of the services at both hospital sites. It should be ensured that suitable systems are in place to accurately capture the work undertaken by the porters, to better inform future roster amendments and to allow monitoring of staff productivity. Rosters should be prepared further in advance in order for staff to know their core shifts and overtime shifts, if any, thus reducing the need for staff to swap shifts if they are unavailable for the overtime they have been allocated. Where there is a need to make use of overtime, efficient use should be made of all available staff.	High	Chief Operating Officer	Facilities Managers – Richard Knowles, Brian Jones, Lisa Rogers.	March 2019 update Will be fully completed when the Porter redesign scheme is fully implemented. Porter redesign includes rota design that will complement existing staff establishment and support services trends and demands. Porter Trac system will be utilised to support this. Progress to date, currently in Stage 3 grievance policy process with staff and trade unions over the implementation of the new rotas and Facilities is being supported with this by workforce business partners.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Raising Concerns	The Health Board should ensure that there is a process in place so that staff without IT access are made aware of their responsibility to raise concerns; this may be through team meetings, induction training and publicity campaigns. The Public Concerns at Work (PCaW) Best Practice guidance recommends: Keep the message fresh: update poster campaigns and intranet resources regularly. New colours, designs, and formats help keep them fresh so staff continue to notice them. Lead from the top: use written and verbal messaging from senior staff members to promote the arrangements.	High	Interim Board Secretary	Interim Board Secretary	January 2019 – now plan to use social media channels and the Chief Executive's blog to raise awareness of the policy, how to raise a concern, and when it might be appropriate to do so, across the Health Board. We will also remind all senior managers of the policy and ask that they ensure that appropriate arrangements are in place for staff without access to IT to be aware of it, including team meetings. We will provide materials (e.g. leaflets and posters) to raise awareness across the Health Board. As part of the induction process, new staff are currently advised of where they can find policies, although the Raising Concerns Policy is not specifically mentioned. They also have information included in their contract advising them if they ever have a concern that something untoward is happening at work and wish to report this to the Organisation in a confidential manner to refer to the Policy. We will repeat these steps periodically to ensure that awareness of the Raising Concerns Policy continues. March 2019 update - In view of the Bridgend boundary change – this has been delayed so that all staff can be reminded of the policy and during the Spring of 2019 a raising awareness campaign will be launched. It was felt that doing this work earlier would potentially confuse staff but as a key policy this will be a priority area. The work will commence before the end of May	Part Completed
Continuing Healthcare	A review of the current arrangements for storing patient CHC files should be undertaken. For all patients where funding is in place or an assessment ongoing, a file (preferably electronic) should be held by the CHC team. An electronic copy of the key documents required as part of the decision making process should be provided by directorates and held on file. If documents cannot be centrally saved to file in this way, a checklist should be in place on file indicating where the original copy of these key documents are being held, the date they were completed, and any key decisions.	Medium	Director of Nursing	Sian Lewis (Lead Nurse for CHC and NHS Funded Care)	Cwm Taf UHB to strengthen quality assurance at directorate level by developing a checklist for each application presented to Clinical Placement Panel. This will be included on the central file and will ensure applications contain necessary documents and then are available and accessible to the central team. March 2019 update - CPP Terms of Reference to be reviewed to ensure quality assurance and scrutiny is understood as part of the CPP's role. New Financial Sign Off being drafted to advise users of the key documentation (Nursing Assessment, Social Work Assessment, Medical Opinion, DST) required for their Unit Panel Application. To encourage users to advise of the date of next review, care co-ordinator, category of care etc.	In progress

Internal Audit Report & Recommendation	Recommendation	Risk / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
	Management should ensure that copies of nursing assessments and appropriately approved CHC Unit Panel forms are retained on file (preferably electronically) for each year that a person is a CHC patient. Management should ensure that key documentation such as nursing assessments are completed in a timely manner to allow the Unit Panel to approve each year's funding request. Consideration should be given to including in the patient file the date the next nursing assessment is due.	Medium	Director of Nursing	Sian Lewis (Lead Nurse for CHC and NHS Funded Care)	The quality assurance process and checklist identified in Finding 3 will encompass the recommendation in Finding 5. The central CHC Team to provide training to the directorate teams to identify the importance of annual reviews and approvals. March 2019 update - Nursing Team currently reviewing: Checklist to be completed for all Unit Panel Applications Central Filing system and where documentation should be held for easy access.	In progress
Medical Equipment and Devices	The risk associated with the pacemakers should be formally recorded. The Health Board should start to consider a process for ensuring medical devices are updated appropriately in order to future proof the processes and prevent future risks from materialising.	Low	Chief Operating Officer	Head of Clinical Engineering	Clinical Engineering have a formal process for dealing with device alerts via MHRA and Manufacturers. (QP11) which would include software updates. Only if the software is of a mandatory update in nature will this process be enacted. Some software updates are available as enhancements to operation and not necessarily security, which would have costs and further training implications. Compatibility of systems also have to be considered when software versions are implemented and compatibility of interchangeable monitor modules/networks etc. A log of the software version is updated on RAM for the associated equipment by the technicians.Clinical Engineering disseminate Medical Device alerts relating to internal pacemakers/internal defibrillators to named contacts in Cardiology. The risk associated with not updating the software in pacemakers will be recorded on the Cardiology department's risk register. March 2019 Report on agenda	In progress
	The Health Board should investigate the reason for this anomaly and rectify to ensure that the integrity of the RAM system is maintained.	Low	Chief Operating Officer	Senior Clinical Technologist	Clinical Engineering are aware of the issue since providing the inventory to the auditor, and have reported to RAM to correct. This field however is actually a hidden field and when producing reports, this field is not actually used. The condemned job date would be used, so this is not an issue in the meanwhile. Informed colleague Nathan of problem 30/08/2018. RAM call log 02480972 to rectify issue when making other corrections.	In progress

Appendix 2

Summary of Outstanding External (Wales Audit Office) Audit Report Recommendations Updated March 2019

Report Title	Lead Director (s)	Report Date	Audit Committee Date	Number of Recommendations Made	Number of Recommendations Achieved	Number of Recommendations Outstanding	Recommendations Not Yet Falling Due	Recommendations Now Out of Date
Clinical Coding	Director of Performance & Planning	Jan-14	Apr-14	4	4	0	0	0
Operating Theatres	Chief Operating Officer	Jan-14	Apr-14	9	9	0	0	0
Primary Care Fraud arrangements	Director of Primary Care, Community & Mental Health	Mar-14	Apr-14	6	6	0	0	0
Follow Up Review Ward Staffing	Nurse Director	Sep-14	Oct-14	2	2	0	0	0
Financial Statements Memorandum	Finance Director	Sep-14	Oct-14	7	7	0	0	0
Annual Audit Report 2014	Board Secretary	Jan-15	Apr-15	5	5	0	0	0
District Nursing Review	Nurse Director	Mar-15	May-15	7	7	0	0	0
Historical Waiting List Anomalies	Director of Planning & Performance / Chief Operating Officer	Mar-15	May-15	3	3	0	0	0
Medicines Management in Acute Hospitals	Board Director	Jun-15	Jul-15	9	9	0	0	0
Orthopaedic Services	Chief Operating Officer	Oct-15	Oct-15	4	4	0	0	0
Financial Statements Memorandum	Director of Finance	Oct-15	Oct-15	7	7	0	0	0
Hospital Catering Follow Up Report	Board Director / Director of Nursing, Midwifery & Patient Services	Jan-16	Jan-16	10	10	0	0	0
Follow Up Outpatients Not Booked * see Below	Chief Operating Officer	Jan-16	Jan-16					

IM&T Audits	Board Director / Director of Finance & Deputy Chief Executive	Jan-16	Jan-16	21	21	0	0	0
Structured Assessment 2015	Board Secretary / Chief Executive	Jan-16	Jan-16	17	17	0	0	0
ICT Capacity & Resource	Director of Primary Care, Community & Mental Health	Apr-16	Apr-16	4	4	0	0	0
Consultant and SAS Contract	Medical Director	Sep-16	Oct-16	16	16	0	0	0
Radiology Review	Chief Operating Officer	May-17	May-17	10	10	0	0	0
Structured Assessment 2016	Board Secretary / Chief Executive	Jan-17	Feb-17	8	8	0	0	0
GP Out of Hours	Director of Primary Care, Community & Mental Health	Sep-17	Sep-17	9	9	0	0	0
Follow Up Review of Outpatient Follow Ups Not Booked *	Chief Operating Officer	Nov 17	Nov 17	5	2	3	0	3
Discharge Planning	Chief Operating Officer	Dec 17	Jan 18	4	3	1	0	1
Structured Assessment 2017	Board Secretary / Chief Executive	Jan 2018	April 2018	7	1	6	0	6 (partially completed)
Primary Care	Director of Primary Care, Community & Mental Health	Dec 2018	Jan 2019	11	3	8	8	0
Structured Assessment 2018	Board Secretary / Chief Executive	Dec 2018	Jan 2019	9	0	9	**(Management response to be presented to April 2019 AC meeting)**	
Totals		**25**		**194**	**167**	**27**	**17**	**13**

Internal Audit Report & Recommendation	Recommendation	Priority / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Review Report Follow Up OPs Not Booked Rec 1	Ensure that there is sufficient information on the clinical risks of delayed follow-up outpatient appointments reported to relevant sub-committees so that the Board can take assurance from monitoring and scrutiny arrangements.	Mar-16	Chief Operating Officer	Chief Operating Officer	The Chief Operating Officer (COO) has presented a detailed report to the Quality, Safety & Risk Committee in May 2018. The Finance, Performance & Workforce Committee is also periodically receiving update reports on the volume of patients in this category. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard. March 2019 The COO has presented detailed reports to the QSR in May and September 2018 and in January and March 2019. The FPW also had an update in March 2019 – will be reported at every QSR committee until clinical risk is understood and outpatients balances	In progress
Review Report Follow Up OPs Not Booked Rec 2	Ensure compliance with revised administrative and booking processes across the organisation to avoid unnecessary retrospective validation of patient records.	Apr-16	Chief Operating Officer	Assistant Director of Operations (Scheduled Care)	In general, positive progress has been made with ensuring revised booking processes are consistently applied across the Health Board. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard. March 2019 In general, positive progress has been made with ensuring revised booking processes are consistently applied across the health board. The planned care programme board has commissioned and completed a project workstream on improving administration and booking processes which has demonstrated positive improvement and the work will be within scope of the recently commissioned internal audit to look at data quality pathway management.	In Progress

Internal Audit Report & Recommendation	Recommendation	Priority / Timescale	Lead Officer	Lead Manager	Reported Position update	Status
Review Report Follow Up OPs Not Booked Rec 4	Develop operational arrangements to deal with the backlog in delayed follow-up appointments, in particular, those specialities or clinical conditions where there is likely to be harm to patients who are delayed.	March 2016	COO	AD Ops Unscheduled Care	The Chief Operating Officer (COO) presented a detailed report to the Quality, Safety & Risk Committee in May 2018. September 2018 - The COO presented a proposal to the Executive Board in July outlining the additional resourcing required to address the back log taking a risk based approach and outlining the project plan in place to strengthen and develop performance. For the first phase £200k was agreed and the first stage for ophthalmology has been instigated. Going forward full updates will be included within the Integrated Performance Dashboard. March 2019 Further work has been undertaken whereby asset owners have been issued with a system reminder to populate the second element of their assets. Work is ongoing to migrate Redcap into SharePoint to align with the system used within the Bridgend hospital sites.	In Progress
Discharge Planning Rec 03	Patient leaflet: Adapt the community hospital patient leaflet so it is relevant for patients staying in acute hospitals, setting out • information about the discharge process, • how the patient and family will be kept informed of the discharge process; • arrangements that the patient may need to make (such as arrange transport); • information about follow-up care; and • the complaints process.	Sept 2018	Chief Operating Officer	Deputy Chief Operating Officer	Progress is being made with engagement, to develop a revised leaflet to better inform discharge planning and address the issues recommended for improvement. It is anticipated this will be progressed to completion during quarter 3.	Ongoing
Structured Assessment 2018	The Management Response to the report's recommendations, finalised and received by the Board in January 2019, will be considered by the April 2019 meeting of the Audit Committee.	April 2018/2019	Chief Executive / Interim Board Secretary	Interim Board Secretary	Management response on agenda-	Management response shared with WAO

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.2.1** **1 April 2019**

Audit Committee Report
MEDICAL EQUIPMENT AND DEVICES – INTERNAL AUDIT ACTION PLAN

Executive Lead: Mr John Palmer, Chief Operating Officer
Author: Mr Russell Hoare, Acting Assistant Director Facilities
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Purpose of Audit Committee Report	
The purpose of the attached update report is to respond to questions raised by Members following the Internal Audit report on Medical Equipment and Devices received at the February 2019 meeting of the Audit Committee. The report outlines actions taken to ensure that the UHB has appropriate focus on the management of medical equipment, including training and an equipment library and location of individual device; it records the significant actions undertaken so far and the proposed target dates for completion of all actions by September 2019.	
Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2018-2021 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are; • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives
Engagement – Who has been involved in this work?	
COO, Clinical Director (CD), Assistant Director of Surgery, Middle Grade Doctors, Directorate Support Manager (DSM), Medical Staffing, Finance Business Partner, HR Business Partner, HEIW, Clinical Business Meeting (CBM) discussions x3 and Rota Manager.	

Audit Committee Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	✓

Recommendation	The Audit Committee is asked to: • **NOTE** the contents of the Report.
Summarise the Impact of the Audit Committee Report	
Equality and diversity	There are no specific equality and diversity issues identified.
Legal implications	Failure to ensure that medical equipment is managed appropriately may contribute to legal action should mistakes occur in the clinical environment.
Population Health	Population health may be impacted upon as a result of either the wrong equipment being used or the equipment not being available. It is anticipated that this is and will be a very unusual circumstance.
Quality, Safety & Patient Experience	Maintained and safe equipment operated by trained staff is vitally important to the quality and safety of the patient experience.
Resources	A large amount of medical equipment held by the Health Board is of significant value and requires appropriate management. This progress report outlines how the UHB will ensure that this is carried out.
Risks and Assurance	The report addresses queries raised by colleagues about the way that the UHB holds and manages equipment, as well as how it trains the staff who undertake its operation. It includes a number of very clear and practical measures that will be undertaken to provide assurance to the Committee.
Health Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy Safe Care Effective Care Dignified Care Timely Care Individual Care Staff & Resources //www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The progress report takes into account many of the related quality themes (as applicable).
Workforce	There are no significant workforce issues other than ensuring that staff are appropriately trained.
Freedom of information status	Open

MEDICAL EQUIPMENT AND DEVICES – INTERNAL AUDIT ACTION PLAN IN CWM TAF UHB

1. SITUATION / PURPOSE OF REPORT

The attached progress update report seeks to outline measures taken to address the issues identified in the Medical Equipment and Devices Internal Audit. The audit outlined a number of areas where the UHB needs to improve its practices and the Audit Committee Member echoed some of these views at its meeting in February 2019. This report addresses those concerns and gives clear actions, timescales and accountable officers to achieve a higher level of assurance and compliance.

2. BACKGROUND / INTRODUCTION

The Audit Report had been given a limited assurance rating with two high, six medium and three low priority recommendations made. The high priority recommendations related to the updating of the medical equipment register, with recognition made that the system was fairly new. The second high priority recommendation related to staff training on the safe use of equipment.

After concern was expressed, the following action was reported:

- the risks identified had been included in the risk register and a full and detailed management response had been provided by the Directorate;
- additional resource would be required to take some of this work forward which would need to be considered as part of the IMTP prioritisation process;
- focused discussions would now take place at Clinical Business meetings.

It was agreed that further action would be taken and reported back at the April meeting of the Audit Committee. This would include consideration of a compilation of a library of equipment, compliance with regulatory guidelines and the reasons behind the non-use of a piece of equipment.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Following on from the last Audit Committee, the Directorate has looked again at the remedial action needed and the key areas that are currently being addressed are as follows:

- The Medical Equipment and Devices Policy is required and being drafted (will be complete by 01 August 2019)
- Key performance indicators (KPIs) and reports are required and will be provided for escalation through the Directorate's monthly Clinical Business Meeting and by exception to the Quality, Safety & Risk Committee
- A Medical Equipment and Devices Governance Board is being established to provide monitoring and scrutiny around equipment and device suitability and purchases (first meeting is planned, process will be completed by 01 August 2019)

- Equipment asset tracking is required and an RF-ID system is currently being piloted (this will be completed by 01 September 2019)
- Equipment library staff will be needed and an investment bid has already been submitted in the Facilities IMTP at a cost of £25,000 (it is anticipated that this will be complete by 01 September 2019)
- A training needs analysis is being undertaken and a training plan and KPIs are being drafted (target date for completion is 01 August 2019)
- Two Medical Equipment and Device Trainers are needed. An investment bid of £80,000 has already been submitted in the Facilities IMTP (target date for completion is 01 August 2019)

Members of the Audit Committee also raised a number of specific issues which they felt needed to be addressed, as follows:

- **Condemned Equipment Not Located**

At the time of the audit, a database transfer had just taken place and a code that was meant for one group of equipment had been applied wrongly to other groups, much of it from hospitals now closed and equipment that has been removed from service due to age or is in fact equipment for which the UHB no longer has responsibility (the Ambulance Trust or the Vale Hospital for example).

In a bid to get a better idea of the true picture, the Directorate has undertaken a review of equipment data for the last two years from August 2017, there were 157 pieces of equipment that could not be found by Clinical Engineering, at an estimated retail value of £291k.

The current situation is, however, not optimal and so a more robust system is now in place. During planned preventative maintenance (PPM), items are given a status which are reported to Departments after their visits. Items are then marked as 'condemned' after three years / three attempts to find, with status 'Device not found on 3rd attempt'. A high level report of missing equipment with its value will be reported through Clinical Business Meetings and the Quality Safety and Risk Committee going forward. It is anticipated that the development of the Medical Equipment & Devices Governance Board will improve focus and scrutiny yet further, and the Directorate is aware that the quality of this information needs to be improved.

- **Baseline Inventory**

Clinical Engineering does hold an inventory of medical devices of which it is aware. It does not hold information on Pathology and Radiology X-Ray devices as these areas have traditionally been managed by the Directorates themselves. The Directorate would welcome taking these areas on if it had the resource to do so to a high standard and discussions are on-going to affect this. Beds, too, are managed by the Directorate (along with mattresses, static foams and dynamics) – with limited staffing to undertake what is a significant workload.

- **Purchasing Controls**

The Directorate does accept that this is an area where there could be improvements and anticipates that the updating of the policy, a review of the purchasing controls to develop a robust system and the development of the Medical Equipment and Devices Governance Board will make a significant contribution to improvement.

The Directorate has also included a request for funding in its IMTP and this will be paramount if the UHB is to make the improvements needed.

- **Non Compliance with Regulatory Guidelines**

The Directorate is aware of the regulatory guidelines – and will refresh the use of them in the policy work that is already underway. Again, the establishment of the Medical Equipment and Devices Governance Board will assist with this process and help to raise the profile of the Directorate and its work.

- **Equipment Locked Away**

The locked equipment issue relates to defibrillators. At the time of the visit of audit staff, one defibrillator had been given to colleagues from the Resuscitation Team to consider how it was to be configured and what staff training was needed. Once this was completed then the Department planned to configure all the new equipment, implement training and issue them for use.

The equipment in question was then, not ready for medical use at that time. Unfortunately, it seems that the appropriate individual was not on site at PCH when the audit team visited as he was at RGH, and the true picture seems to have been lost.

- **Equipment Purchased and Not Used**

The Directorate has made enquiries about the capital purchase of equipment that has not been used.

The equipment in question is a specialist camera and scope stack system for patients with dysphagia (a specialist piece of equipment used to analyse the swallow of patients of the Speech and Language Service) and was bought in 2017 ahead of the refurbishment of PCH so that the SALT Service would be able to mirror a service that it provides in RGH with a similar piece of equipment.

A decision was taken to purchase the equipment ahead of the refurbishment because the x-ray suite at PCH was (prior to its refurbishment) unable to support the stack due to incompatibility caused by age and SALT colleagues were always aware that there would be a lapse of time before it could be used.

The equipment facilitates a "gold standard" for patients with swallowing problems and allows a more accurate diagnosis, improving forward treatment planning.

The service will start as soon as the Videofluoroscopy Suite in X-ray (PCH) is finished which is anticipated in the near future.

4. RECOMMENDATION

Members of the Audit Committee are asked to:

- **NOTE** the contents of the Progress Report and the plans to reach compliance.

Freedom of information status	Open

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.3** **1 April 2019**

Audit Committee Report
SCHEME OF DELEGATION REPORT

Executive Lead: Director of Finance
Author: Head of Finance (Financial Accounts, Capital & Systems)
Contact Details for further information: Huw Evans on 01443 443810 or huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.12.18 to 28.2.19; To provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP).

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2018-2021 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A
Engagement – Who has been involved in this work?	
NHS Wales Shared Services Partnership	

Audit Committee Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is asked to: • **NOTE** the position on procurement matters for the period 1.12.18 to 28.2.19; • **NOTE** the update regarding Purchase to Pay.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No specific impact						
Legal implications	No specific impact						
Population Health	No specific impact						
Quality, Safety & Patient Experience	No specific impact						
Resources	Assists in providing assurance that appropriate value for money is obtained where competitive tenders have not been sought, and ensures resources are deployed according to set control processes						
Risks and Assurance	Purchase to Pay processes are a key risk area for the UHB, which has contributed to a failure to meet the prompt payment target of 95% non-NHS invoices to be paid within 30 days in previous years.						
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources.						
Workforce	No specific impact						
Freedom of information status	Open						

SCHEME OF DELEGATION REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of the report is to:

- Report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.12.18 to 28.2.19; and
- Provide an update on the work undertaken to improve the Purchase to Pay processes, in conjunction with the NHS Wales Shared Services Partnership (NWSSP) and

2. BACKGROUND

The following areas within the Scheme of Delegation may be considered contentious and therefore the Audit Committee may wish to be given the opportunity to ask questions or request further information:

a) Engagement off contract of non-medical staff not paid via the payroll. The Director of Workforce and Organisational Development (W&OD) and the Head of Procurement would need to confirm agreement prior to any commitment.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

c) Contracts requiring Ministerial approval (over £1m)

This report provides details of any such transactions within the period 1.12.18 to 28.2.19.

The report also provides an update on the Prompt Payment compliance for 2018-19

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Procurement Matters

a) Engagement off contract of non-medical staff not paid via the payroll

There were no engagements or contracts entered into during the period 1.12.18 to 28.2.19.

b) Waiver of competitive tenders, as authorised by the Chief Executive.

Standing Financial Instructions require 4 competitive tenders for supplies of goods and services over £25,000 up to Official Journal of the European Union (OJEU) thresholds (currently £118,133) and 5 competitive tenders above OJEU thresholds up to £1m. Purchases over £1m require Ministerial approval.

The Scheme of Delegation allows the Chief Executive to approve a waiver of the requirement for competitive tenders up to OJEU or other exceptions to tender rules. **Table A** below provides details of such actions during the period 1.12.18 to 28.2.19.

Table A – Single Tender Actions 1.12.18 to 28.02.19

STA	Division	Contract description	Supplier	Contract Value Exc Vat	Reason for approval	Date Returned
SQT1026	National Imaging Academy	OsiriX MD Licences for training	Pixmeo SARL	£30,240	a), b) & c)	21.12.18
SQT1032	CAMHS	Agency Staff	CAMHS Professionals	£29,910	b) & c)	11.01.19
SQT1036	Urology	Outsourcing Urology Services	Sancta Maria Hospital (SMH)	£60,750	d)	31.01.19

Reasons for approval:
(a) Service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition)
(b) Compatibility issue
(c) Genuinely only one provider
(d) Need to retain particular contractor for real business continuity issues; not preferences

The following provides an additional context around the outsourcing Single Quotation Tender (SQT) for Urology.

SQT1036 – Outsourcing

Funding was agreed in early January to secure additional urology capacity through external outsourcing to deliver Referral to Treatment Targets (RTT) by 31 March 2019. Existing local providers did not have capacity and following extensive searching of an outsourcing supplier, capacity was identified in Sancta Maria Hospital.

Due to time constraints with 8 weeks until year end, the Directorate needed to ensure this outsourcing arrangement was confirmed by 25 January 2019. This was necessary to have enough time to ensure the treatment of all patients by 31 March 2019 and to manage the patients safely through the appropriate surgical pathway. There was insufficient time to go through the All Wales Framework 6 week competitive process. However, Sancta Maria Hospital provided framework rates in line with the All Wales framework to ensure Value for Money (VFM). All work was done in line with NHS Terms & Conditions for services

c) Contracts requiring Ministerial approval (over £1m)

The following contract received ministerial approval during this period.

Division	Contract description	Contract period	Supplier	Contract Value excluding Vat	Ministerial Notification – pre-tender Approval – Contract award
ICT/Medical records	EDRMS & Digitisation	5 Years 01.03.19 – 28.02.24	Civica	£7,000,000	Approval

3.2. Purchase to Pay (P2P)

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-18	7,528	16,162,134	7,960	16,933,681	94.6	95.4
May-18	12,425	21,324,160	12,968	22,061,869	95.8	96.7
Jun-18	14,280	19,051,050	14,869	20,097,298	96.0	94.8
Jul-18	8,379	17,008,664	8,677	17,790,226	96.6	95.6
Aug-18	13,099	25,707,783	13,614	26,714,775	96.2	96.2
Sept 18	11,437	19,137,306	11,915	20,409,027	96.0	93.8
Oct 18	11,655	21,054,810	11,987	21,772,821	97.2	96.7
Nov 18	12,409	21,713,494	12,849	22,628,035	96.6	96.0
Dec 18	10,077	11,673,645	10,476	12,550,275	96.2	93.0
Jan 19	11,479	25,642,067	12,089	26,378,082	95.0	97.2
Feb 19	10,549	19,740,266	11,042	20,703,718	95.5	95.3
YTD	123,317	218,215,381	128,446	228,039,807	96.0	95.7

The Health Board is meeting its 95% target of paying non-NHS invoices within 30 days during 2018/19, with an accumulated position for the year of 96.0% (95.7% in value terms). This compares to 95.3% (value 96.5%) in 2017/18.

The NHS invoice position shows that 74.7% of invoices were paid within 30 days for the year to date. (74.1% in 2017/18).

3.3 Scheme of Delegation/Financial Control Procedures

There are no proposed changes to the Scheme of Delegation or Financial Control Procedures for this meeting.

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the position on procurement matters for the period 1.12.18 to 28.2.19;
- **NOTE** the update regarding Purchase to Pay.

Freedom of information status	Open

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.4** **1 April 2019**

Audit Committee Report
LOSSES AND SPECIAL PAYMENTS 01.12.18 TO 28.02.19

Executive Lead: Director of Finance
Author: Financial Accountant
Contact Details for further information: Daxa Varsani on 01443 443808 or daxa.varsani@wales.nhs.uk or Huw Evans huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To advise the Audit Committee on the losses and special payments made by the UHB for the period 1 December 2018 to 28 February 2019, as required in Standing Financial Instructions.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2018-2021 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A

Engagement – Who has been involved in this work?
NWSSP – legal services and Risk Pool

Audit Committee Resolution To;							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is requested to: • **NOTE** the losses and special payments incurred for the period 1 December 2018 to 28 February 2019						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	No specific impact
Legal implications	Losses provided for are informed by legal advice where appropriate based on probability of a successful claim
Population Health	No specific impact
Quality, Safety & Patient Experience	The majority of losses and special payments are as a result of things going wrong and where quality, safety or patient experience may therefore have been compromised. Details of medical negligence and personal injury claims are provided quarterly to the Concerns (Claims) Scrutiny Panel who subsequently reports to the Quality, Safety & Risk Committee
Resources	The report highlights the resource impact of losses both in expenditure and cash terms. It also highlights the level of provision within the balance sheet for potential future payments.
Risks and Assurance	Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.
Health and Care Standards	Standards for Health Services Reference Governance & Accountability Framework (1);
Workforce	No specific impact
Freedom of information status	Open

LOSSES AND SPECIAL PAYMENTS 01.12.18 to 28.02.19

1. SITUATION / PURPOSE OF REPORT

This report advises the Audit Committee on the losses and special payments made by the University Health Board (UHB) for the three month period from 1 December 2018 to 28 February 2019, as required in Standing Financial Instructions.

2. BACKGROUND/INTRODUCTION

The report summarises the overall financial impact of losses in this financial year and provides detail on individual payments for write-off.

The Health Board is liable for the first £25k of any Personal Injury or Medical Negligence claim (not including Redress cases), with amounts over this being borne by the Welsh Risk Pool (WRP) managed by the NHS Wales Shared Services Partnership (NWSSP). For any "other" cases such as Employment Matters or Voluntary Early Release (VER) for example, the full cost of the loss is borne by the UHB. Where the WRP would be liable for a reimbursement to the UHB then there will be timing differences between payments being made and any reclaim from the Risk Pool. There is a strict protocol in place for reclaiming from the WRP.

In accounting for losses on claims, liability is recognised when legal advice states that there is a probability in excess of 50% of the Health Board having to settle. The quantum of the claim, and associated plaintiff costs are therefore recognised as "expenditure" at this point, with the risk pool recovery element also being recognised. Other losses are recognised as and when they arise.

There is therefore a significant timing issue (which can be several years) between expenditure being recognised within the Health Board's accounts and cash payments being made. Write-off approval action is only required for cash payments. This report highlights:

a) Amounts that have been charged to expenditure for which payments are yet to be made. These amounts are held within the balance sheet as future amounts owing (or owed by the WRP) at the appropriate Balance Sheet date;

b) Amounts charged to expenditure during the current year (together with income from the WRP), and which therefore has a budgetary impact against the Health Board's Revenue Resource Limit; and

c) Cash payments made during the period for which write-off action is required, with details being provided within the appendices.

a) Provision and Creditors as at 28 February 2019

This is shown in table 1 below, together with equivalent figures at the end of the last three financial years, and the end of November 2018 which is the previous reporting date to the Audit Committee.

Table 1

	28.02.19	30.11.18	31.03.18	31.03.17	31.03.16
	£000	£000	£000	£000	£000
Medical Negligence claims/costs	87,985	90,926	78,961	68,215	50,246
Personal Injury claims/costs	467	411	1,618	784	884
Recoverable from Welsh Risk Pool	(99,509)	(99,598)	(87,408)	(75,527)	(54,849)
Net claim provision	**(11,057)**	**(8,261)**	**(6,829)**	**(6,528)**	**(3,719)**
Permanent Injury Benefit	4,738	3,265	3,258	3,413	3,249
Other	0	0	0	0	0
Net Provision	**(6,319)**	**(4,996)**	**(3,571)**	**(3,115)**	**(470)**
Number of live cases on losses system (LaSPaR)					
	28.02.19	**30.11.18**	**31.03.18**	**31.03.17**	**31.03.16**
Medical Negligence claims	328	301	397	502	445
Personal Injury claims	97	92	91	100	122

The Audit Committee will be aware that any overspend incurred by the Welsh Risk Pool will need to be shared amongst NHS organisations, and is therefore an additional financial risk to those organisations. However, it is now confirmed that the Risk Sharing Agreement will not be invoked for this year.

There is a reduction in medical negligence claim provision which is due to a reduction in estimated settlement costs for a small number of cases.

The increase in permanent injury benefit provision is due to one new case as detailed within Section B of this report.

The increase in number of medical negligence claims during this period is due to an increase in the number of redress cases logged during this period. Additionally there are a number of recently settled cases for which the Welsh Risk Pool reimbursement is awaited and thus remain live until fully settled.

b) Expenditure incurred for the year to 28 February 2019

This is shown in table 2 below, together with equivalent figures for the last three complete financial years and last reporting period to the Audit Committee (30.11.2018).

The net claim expenditure to date for the financial year 2018/19 is £1,571k (monthly expenditure of £142k), which is higher than the previous financial year (monthly expenditure £133K).

The annual budget for net claim expenditure for 2018-19 is £1.334m (year to date £1,223k). There is therefore a month 11 overspend on claims of £348k included within the Health Board's position.

The negative personal injury claim expenditure is due to a marked reduction in settlement cost during the year for one particular case, which had been provided at the higher amount last year.

The increase in Personal Injury Benefit expenditure of £1.64m is due to the new case which was reported to the Committee previously. Welsh Government have funded the total cost of this claim, thus negating any financial impact to the Health Board.

The "other" category mainly consists of payment of retirement gratuities, Employment Matters and voluntary early releases (see Appendix 4).

Table 2 **Expenditure incurred year to date**

Definition - Payments made during the year +/- changes in provisions

	Year to	Year to	Year ended	Year ended	Year ended
	28.02.19	**30.11.18**	**31.03.18**	**31.03.17**	**31.03.16**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	18,435	17,969	29,014	18,932	19,381
Personal Injury claims/costs	(520)	(651)	1,612	555	241
Recoverable from Welsh Risk Pool	(16,344)	(16,000)	(29,033)	(18,164)	(17,651)
Net claim expenditure	**1,571**	**1,318**	**1,593**	**1,323**	**1,971**
Permanent Injury Benefit	1,703	62	62	384	150
Other	91	80	174	310	(664)
Net I/E impact	**3,365**	**1,460**	**1,829**	**2,017**	**1,457**

Cash Write-Offs made for the period 1 December 2018 to the 28 February 2019

Table 3 shows the cash impact for financial year 2018-19 and up to 28 February 2019 of the current financial year. More detail is provided within the appendices for the current reporting period.

An analysis of medical negligence payments and receipts over cases for the last quarter is shown in **Appendix 1.** A similar analysis is provided for personal injury claims in **Appendix 2** and Permanent Injury Benefit (PIB) in **Appendix 3.**

Other write-offs relate to ex-gratia payments approved by the Chief Executive or Deputy Chief Executive, Employment Claim Matters and debt write offs. The ex-gratia payments include gratuities provided to staff on retirement with more than 20 years' service, in line with Human Resource (HR) policy, and voluntary early release payments. These are shown in **Appendix 4.**

Table 3
Cash write-offs made during year to date 18/19

	01.12.18 - 28.02.19 £000	Previously reported £000	2018-19 £000
Medical Negligence (Appendix 1)			
Claims	2,510	4,029	6,539
Costs	789	1,600	2,389
Defence Fees	106	376	482
Personal Injury (Appendix 2)			
Claims	13	345	358
Costs	46	124	170
Defence Fees	16	87	103
Permanent Injury Benefit (Appendix 3)	167	55	222
Other (Appendix 4)			
Ex-Gratia	11	36	47
Debt Write Off	0	0	0
Employment Matter	1	44	45
Total	**3,659**	**6,696**	**10,355**
Recovered from Welsh Risk Pool	(433)	(3,810)	(4,243)
Net Cash Write-Off	**3,226**	**2,886**	**6,112**

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Standing Financial Instructions require all losses to be reported to the Audit Committee. This report is therefore a key element of the governance process around losses and special payments.

The number of claims, both Medical Negligence and Personal Injury, continues to result in significant levels of expenditure. These levels of expenditure are determined case by case and are based on information supplied by Welsh Legal Services.

4. RECOMMENDATION

The Audit Committee is requested to:

- **NOTE** the losses and special payments made for the period 1 December 2018 to 28 February 2019.

Freedom of information status	Open

Medical Negligence Payments 01/12/2018-28/02/2019							Appendix 1
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
08RVEMN0013	0	7,113	0	0	7,113	106,618	113,730
12RYLMN0037	0	2,620	0	0	2,620	14,255	16,875
13RYLMN0029	0	1,256	0	0	1,256	26,757	28,012
14RYLMN0006	0	1,913	0	0	1,913	27,168	29,080
14RYLMN0010	47,500	0	0	0	47,500	422,560	470,060
14RYLMN0127	0	4,613	20,000	0	24,613	126,643	151,255
14RYLMN0145	0	0	0	-10,656	-10,656	35,656	25,000
14RYLMN0169	0	912	0	0	912	302,520	303,432
14RYLMN0198	45,000	2,250	-28,277	0	18,973	290,867	309,840
14RYLMN0208	32,000	1,000	0	0	33,000	352,616	385,616
14RYLMN0209	10,000	0	0	0	10,000	242,568	252,568
14RYLMN0214	30,000	1,100	0	0	31,100	246,276	277,376
15RYLMN0078	0	200	0	0	200	41,329	41,529
16RYLMN0042	0	0	0	-43,179	-43,179	68,179	25,000
16RYLMN0074	0	465	0	0	465	124,331	124,796
16RYLMN0079	0	0	506	0	506	21,494	22,000
17RYLMN0063	0	0	25,000	0	25,000	3,990	28,990
17RYLMN0185	60,000	4,131	0	0	64,131	638,048	702,179
18RYLMN0059	0	3,303	0	0	3,303	6,220	9,523
07RRSMN0006	0	-523	0	523	0	25,000	25,000
14RYLMN0178	0	3,835	0	0	3,835	81,980	85,815
15RYLMN0115	0	1,400	0	0	1,400	4,138	5,538
15RYLMN0136	39,000	0	0	0	39,000	25,200	64,200
16RYLMN0121	8,500	0	0	0	8,500	7,588	16,088
16RYLMN0139	0	0	50	0	50	5,715	5,765
17RYLMN0122	10,000	0	0	0	10,000	14,270	24,270
13RYLMN0131	0	1,404	0	0	1,404	843,210	844,614
14RYLMN0062	0	5,150	994,000	0	999,150	71,830	1,070,980
14RYLMN0135	50,000	125	0	0	50,125	214,957	265,082
16RYLMN0131	10,000	3,543	17,000	0	30,543	9,321	39,864
16RYLMN0165	0	0	7,000	0	7,000	2,450	9,450
17RYLMN0150	0	200	0	0	200	5,800	6,000
18RYLMN0119	2,993	0	4,000	0	6,993	1,746	8,739
15RYLMN0070	0	0	0	-15,497	-15,497	40,497	25,000
17RYLMN0071	0	3,368	0	0	3,368	550	3,918
17RYLMN0190	25,000	0	45,000	0	70,000	2,770	72,770
06RRSMN0037	0	1,330	0	0	1,330	8,419	9,749
10RYLMN0065	15,000	0	0	0	15,000	31,297	46,297
14RYLMN0012	54,000	0	0	0	54,000	89,200	143,200
15RYLMN0004	0	1,350	0	0	1,350	3,098	4,448
16RYLMN0138	0	1,163	0	0	1,163	39,779	40,942
16RYLMN0145	0	3,081	0	0	3,081	3,184	6,265
16RYLMN0193	37,500	0	0	0	37,500	173,855	211,355
17RYLMN0194	-3,960	0	0	0	-3,960	62,000	58,040

15RYLMN0093	0	1,100	0	0	1,100	146,086	147,186
15RYLMN0106	25,000	850	0	0	25,850	7,480	33,330
16RYLMN0010	0	1,535	0	0	1,535	11,750	13,285
16RYLMN0115	25,000	0	0	0	25,000	15,060	40,060
17RYLMN0067	16,000	0	0	0	16,000	41,787	57,787
17RYLMN0120	0	600	0	0	600	985	1,585
19RYLMN0021	0	1,485	0	0	1,485	440	1,925
16RYLMN0078	0	1,350	850,000	0	851,350	57,561	908,911
16RYLMN0205	0	3,925	0	0	3,925	2,125	6,050
17RYLMN0061	10,000	0	0	0	10,000	80,420	90,420
17RYLMN0126	10,000	0	0	0	10,000	32,354	42,354
18RYLMN0057	33,000	0	0	0	33,000	31,684	64,684
11RYLMN0068	25,250	0	0	0	25,250	393,780	419,030
15RYLMN0040	0	1,650	0	0	1,650	14,795	16,445
15RYLMN0109	95,000	0	150,000	0	245,000	2,413	247,413
15RYLMN0169	0	2,500	0	0	2,500	1,538	4,038
16RYLMN0098	0	0	10,000	0	10,000	19,892	29,892
17RYLMN0030	1,600	0	15,000	0	16,600	1,500	18,100
17RYLMN0070	0	0	38,250	0	38,250	23,657	61,907
17RYLMN0111	0	580	0	0	580	0	580
17RYLMN0162	0	1,500	0	0	1,500	59	1,559
18RYLMN0117	5,600	0	46,250	0	51,850	58	51,908
19RYLMN0051	0	0	25,000	0	25,000	0	25,000
19RYLMN0055	0	0	250	0	250	0	250
10RYLMN0014	0	0	2,016	0	2,016	7,466	9,482
10RYLMN0092	0	2,268	0	0	2,268	372,857	375,125
12RYLMN0004	0	0	110,000	0	110,000	780,464	890,464
14RYLMN0193	0	0	5,000	0	5,000	38,290	43,290
15RYLMN0010	0	600	0	0	600	1,946,886	1,947,486
15RYLMN0018	18,000	0	0	0	18,000	364,178	382,177
15RYLMN0075	0	190	30,000	0	30,190	1,850	32,040
15RYLMN0104	0	1,000	0	0	1,000	4,231	5,231
15RYLMN0130	0	350	0	0	350	50	400
15RYLMN0159	0	0	0	-95,727	-95,727	120,727	25,000
16RYLMN0086	0	81	0	0	81	28	110
16RYLMN0106	0	349	0	0	349	2,100	2,449
16RYLMN0142	5,125	0	0	0	5,125	31,767	36,892
17RYLMN0054	0	800	0	0	800	32	832
17RYLMN0073	0	50	0	0	50	500	550
17RYLMN0089	3,200	0	1,500	0	4,700	1,450	6,150
17RYLMN0115	0	5,490	0	0	5,490	1,640	7,130
17RYLMN0160	0	50	0	0	50	0	50
17RYLMN0165	0	800	0	0	800	60	860
17RYLMN0188	0	2,129	0	0	2,129	1,494	3,623
18RYLMN0039	0	1,200	0	0	1,200	50	1,250
18RYLMN0047	4,000	0	0	0	4,000	48,154	52,154
18RYLMN0068	0	2,470	0	0	2,470	525	2,995
19RYLMN0049	0	2,500	0	0	2,500	0	2,500

19RYLMN0052	0	0	17,000	0	17,000	0	17,000
19RYLMN0057	0	0	500	0	500	0	500
19RYLMN0058	0	0	250	0	250	0	250
19RYLMN0059	0	0	1,750	0	1,750	0	1,750
14RYLMN0080	17,500	3,174	0	0	20,674	116,850	137,524
16RYLMN0073	0	0	10,000	0	10,000	30,055	40,055
16RYLMN0095	0	925	0	0	925	3,068	3,993
16RYLMN0102	0	50	0	0	50	50	100
16RYLMN0147	7,000	0	0	0	7,000	12,535	19,535
16RYLMN0156	0	0	18,831	0	18,831	1,690	20,521
17RYLMN0037	0	600	0	0	600	4,333	4,933
17RYLMN0038	0	0	36,500	0	36,500	5,361	41,861
17RYLMN0140	0	0	12,509	0	12,509	4,036	16,545
17RYLMN0144	1,600	22	2,000	0	3,622	1,672	5,294
17RYLMN0174	0	22	0	0	22	115	137
17RYLMN0175	0	1,600	0	0	1,600	24,600	26,200
17RYLMN0191	0	50	0	0	50	0	50
18RYLMN0011	0	50	0	0	50	0	50
18RYLMN0058	4,500	0	0	0	4,500	5,350	9,850
18RYLMN0064	0	2,625	0	0	2,625	0	2,625
18RYLMN0126	1,600	0	4,800	0	6,400	122	6,522
18RYLMN0134	0	22	0	0	22	14	36
19RYLMN0016	0	14	0	0	14	173	187
19RYLMN0027	0	750	0	0	750	0	750
19RYLMN0030	6,000	0	0	0	6,000	0	6,000
19RYLMN0036	1,600	0	11,000	0	12,600	0	12,600
19RYLMN0053	0	0	20,000	0	20,000	0	20,000
19RYLMN0063	0	0	6,000	0	6,000	0	6,000
19RYLMN0064	0	0	250	0	250	0	250
19RYLMN0065	0	0	1,000	0	1,000	0	1,000
19RYLMN0068	0	375	0	0	375	0	375
19RYLMN0069	0	0	500	0	500	0	500
19RYLMN0070	0	1,500	0	0	1,500	0	1,500
19RYLMN0071	0	950	0	0	950	0	950
REDRESS WRP REIMBURSEMENT				-268,000	-268,000	-78,000	-346,000
Total 01/12/2018 - 28/02/2019	**789,108**	**106,431**	**2,510,436**	**-432,536**	**2,973,437**	**9,608,191**	**12,581,628**

Personal Injury Payments 01/12/2018-28/02/2019 — Appendix 2

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
16RYLPI0010	26,000	0	0	0	26,000	20,560	46,560
16RYLPI0020	8,500	0	0	0	8,500	3,589	12,089
16RYLPI0032	3,000	0	0	0	3,000	15,655	18,655
16RYLPI0035	0	1,244	0	0	1,244	16,636	17,879
17RYLPI0012	0	1,042	0	0	1,042	50	1,092
17RYLPI0017	0	1,014	0	0	1,014	0	1,014
17RYLPI0024	1,080	0	1,200	0	2,280	12,416	14,696
18RYLPI0014	0	2,545	0	0	2,545	0	2,545
18RYLPI0015	0	3,638	647	0	4,285	0	4,285
18RYLPI0016	0	768	0	0	768	0	768
18RYLPI0018	0	874	0	0	874	4,110	4,984
18RYLPI0026	0	1,293	0	0	1,293	0	1,293
18RYLPI0028	1,598	1,024	3,700	0	6,322	0	6,322
18RYLPI0029	900	0	1,505	0	2,405	3,920	6,325
18RYLPI0038	0	1,800	0	0	1,800	0	1,800
19RYLPI0005	0	1,100	0	0	1,100	4,524	5,624
19RYLPI0007	1,897	0	1,500	0	3,397	0	3,397
19RYLPI0008	1,710	0	2,000	0	3,710	0	3,710
19RYLPI0016	0	0	1,200	0	1,200	0	1,200
19RYLPI0024	1,125	0	1,000	0	2,125	0	2,125
Total 01/12/2018 - 28/02/2019	**45,809**	**16,340**	**12,752**	**0**	**74,901**	**81,460**	**156,360**

Permanent Injury Benefit 01/12/2018 - 28/02/2019			Appendix 3
Laspar Number	**In period Payments £**	**Previous Write-Offs £**	**Cumulative £**
01RRSPI0020	6,609	179,474	186,083
02RVEPI0001	3,146	37,824	40,970
02RVEPI0003	4,971	130,173	135,144
02RVEPI0004	3,410	89,348	92,758
03RRSPI0020	23,172	646,921	670,093
03RVEPI0028	6,253	206,366	212,619
04RRSPI0009	6,792	170,730	177,522
04RRSPI0024	5,642	109,942	115,584
05RRSPI0020	2,703	55,164	57,867
05RRSPI0021	5,916	138,543	144,459
05RVEPI0033	9,159	211,307	220,466
05RVEPI0034	2,620	62,698	65,318
08RVEPI0009	6,195	134,110	140,305
10RYLPI0070	3,499	76,458	79,957
11RYLPI0065	10,065	155,092	165,157
12RYLPI0059	3,475	42,797	46,272
13RYLPI0020	1,843	21,701	23,544
13RYLPI0050	6,051	88,862	94,913
98RVEPI0005	196	5,290	5,486
19RYLPI0022	55,601	-	55,601
Grand Total	**167,318**	**2,562,800**	**2,730,118**

Other Payments 01/12/2018 - 28/02/2019			Appendix 4
Case Reference	**Nature of Loss**	**Details**	**Amount £**
19RYLEG0133	Ex-Gratia	Loss of Nightdress	20
19RYLEG0134	Ex-Gratia	Dentures broken	40
19RYLEG0113	Ex-Gratia	Retirement Gratuity	218
19RYLEG0114	Ex-Gratia	Retirement Gratuity	376
19RYLEG0115	Ex-Gratia	Retirement Gratuity	371
19RYLEG0116	Ex-Gratia	Retirement Gratuity	314
19RYLEG0117	Ex-Gratia	Retirement Gratuity	224
19RYLEG0118	Ex-Gratia	Retirement Gratuity	234
19RYLEG0119	Ex-Gratia	Retirement Gratuity	235
19RYLEG0120	Ex-Gratia	Retirement Gratuity	267
19RYLEG0121	Ex-Gratia	Retirement Gratuity	284
19RYLEG0122	Ex-Gratia	Retirement Gratuity	332
19RYLEG0123	Ex-Gratia	Retirement Gratuity	333
19RYLEG0124	Ex-Gratia	Retirement Gratuity	322
19RYLEG0125	Ex-Gratia	Retirement Gratuity	361
19RYLEG0126	Ex-Gratia	Retirement Gratuity	225
19RYLEG0127	Ex-Gratia	Retirement Gratuity	410
19RYLEG0128	Ex-Gratia	Retirement Gratuity	225
19RYLEG0129	Ex-Gratia	Retirement Gratuity	238
19RYLEG0130	Ex-Gratia	Retirement Gratuity	284
19RYLEG0131	Ex-Gratia	Retirement Gratuity	304
19RYLEG0132	Ex-Gratia	Retirement Gratuity	284
19RYLEG0135	Ex-Gratia	Retirement Gratuity	294
19RYLEG0136	Ex-Gratia	Retirement Gratuity	372
19RYLEG0137	Ex-Gratia	Retirement Gratuity	343
19RYLEG0138	Ex-Gratia	Retirement Gratuity	446
19RYLEG0139	Ex-Gratia	Retirement Gratuity	392
19RYLEG0140	Ex-Gratia	Retirement Gratuity	196
19RYLEG0141	Ex-Gratia	Retirement Gratuity	392
19RYLEG0142	Ex-Gratia	Retirement Gratuity	402
19RYLEG0143	Ex-Gratia	Retirement Gratuity	304
19RYLEG0144	Ex-Gratia	Retirement Gratuity	206
19RYLEG0145	Ex-Gratia	Retirement Gratuity	323
19RYLEG0146	Ex-Gratia	Retirement Gratuity	206
19RYLEG0147	Ex-Gratia	Retirement Gratuity	435
19RYLEG0148	Ex-Gratia	Retirement Gratuity	216
19RYLEG0149	Ex-Gratia	Retirement Gratuity	245
19RYLEG0150	Ex-Gratia	Retirement Gratuity	196
19RYLEG0151	Ex-Gratia	Retirement Gratuity	353
18RYLEG0214	Employment Matter	VER - Wage Arrears	680
Total 01/12/2018 - 28/02/2019			**11,220**

FP ??

GIG CYMRU NHS WALES | Bwrdd Iechyd Cwm Taf Health Board

FINANCIAL CONTROL PROCEDURE:
MEDICAL VARIABLE PAY
DRAFT – SUBJECT TO CONSULTATION

Initiated by:	Director of Finance & Procurement/ Director of Workforce and Organisational Development
Approved by:	To go to Audit Committee
Date approved:	To be approved
Operational Date:	TBC
Date for review:	TBC
Distribution:	Executive Directors Board Secretary Clinical Directors Directorate Managers Assistant Directors Heads of Department Sharepoint

Freedom of Information Status: Open

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1. Scope & Principles

2. Agency Locum Rates

3. Agency Locum Control Framework Deployment

4. Ad Hoc Locum Cover

5. Records Management

6. Equality impact assessment

1.0 SCOPE & PRINCIPLES

1.1 This procedure details the controls over the UHB's medical variable pay and recognises the engagement and payment of medical locums is processed via a managed service by Retinue Health.

1.2 The procedure should be read in conjunction with the Welsh Health Circular (WHC/2017/042) 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales'. The intention of the Circular is to increase the equity and transparency of reward systems and reduce internal wage competition, both within the Health Board and across the NHS in Wales.

1.3 The procedure details a consistent process for the monitoring, verification and payment of agency locum spend and sets out clear roles and responsibilities for approving, engaging, paying and monitoring.

1.4 The procedure also clearly defines the use of Additional Duty Hours (ADH) and Waiting List Initiatives (WLI).

1.5 The Medical Director (or nominated deputy) is responsible for authorising in advance any breaches of the Welsh Government Capped Rate as set out in the Welsh Health Circular.

1.6 The Health Board must endeavour to use the approved framework agreement; Crown Commercial Services (CCS) RM3711 Multidisciplinary Temporary Healthcare Personnel Framework; to procure all medical and dental agency workers.

1.7 Where the Health Board is unable to source a suitable locum through the approved framework supply chain, prior authorisation will be required from the Medical Director (or nominated deputy).

2.0 AGENCY LOCUM RATES

2.1 A price cap has been applied by Welsh Government for all Medical and Dental Agency workers (Excluding Primary Care). These caps are the maximum payments allowed and are set out in table 1 below (rates are at November 2017 and will be subject to inflationary uplifts):

Table 1 – Capped rates for agency locum

Grade and Shift	Cap hourly rate
Foundation Year 1	£32.54
Foundation Year 2	£40.36
Registrar (SP1-2)/Core Medical Training	£45.76
Registrar (SP3+)	£57.05
Dental Core Training	£56.15
Specialty Doctor/Staff Grade	£66.43
Associate Specialist	£82.21
Consultant	£97.22

2.2 Price caps are exclusive of VAT.

2.3 The rate is the total rate to be paid to agencies supplying medical and dental staff and includes all additional costs such as agency commission, allowance for holiday pay, travel costs and accommodation costs.

2.4 Where there is a requirement to breach the cap rate for agency locum engagements, payments must be authorised in advance by the Medical Director (or a nominated deputy).

When considering a breach submitted by a directorate, the overarching principle is to consider the risk to the delivery of safe services and patient care and safety, whist also attempting to:

i) Renegotiate the rates down/below cap
ii) Consider alternative skills
iii) Consider the rota/shift patterns
iv) Take into consideration coverage through existing workforce

3.0 AGENCY LOCUM CONTROL FOR DEPLOYMENT

3.1 All rota gaps must be identified using the Health Roster system and the rota gaps to be filled via ADHs or agency locum must be approved by the Directorate Manager. This approval also confirms the gaps are for posts that are within the agreed funded establishment.

3.2 All agency bookings must be made via the managed service provided by Retinue Health.

3.3 Once a shift has been worked by an agency locum the shift must be confirmed and 'finalised' in Health Roster by the Directorate Team and the hours worked amended if necessary.

3.4 All doctors' timesheets must be completed by the locum and approved by the Directorate Manager against the Health Roster system. This approval will also serve as the Manager's approval for payment.

3.5 All agency locums booked via the Direct Engagement process will be paid by the Health Board. The payments will be processed weekly by the Payroll Services of the NHS Wales Shared Service Partnership (NWSSP).

3.6 Agency locums not booked via Direct Engagement will be paid via the Accounts Payable Services of the NHS Wales Shared Service Partnership (NWSSP).

3.7 The Health Board will receive a consolidated weekly invoice from Retinue Health, which will also include the agency commission and the managed service fee as per the agreed rate card.

3.8 The invoice will be validated against the Health Roster system by the E Rostering Team before it is sent to Accounts Payable for processing on a consolidated invoice template.

3.9 All data is captured through Retinue Health, providing centralised bespoke reporting as and when required for Welsh Government and for internal reporting.

4.0 AD HOC LOCUM COVER

4.1 Ad hoc locum cover can be provided by substantive staff on an additional basis (i.e. additional to contracted hours/sessions), shift by shift basis, or by individuals secured on ad hoc terms of engagement. Ad hoc locum cover includes:

- Additional duty hours (ADHs)
- Internal locum cover
- Internal medical bank
- Ad hoc cover

4.2 Covering/backfilling weekday planned activities – ad hoc locum activity:
Medical staff also provide "backfill" for routine activity for example, out-patient clinics and theatre lists, and this will be remunerated at the ad hoc locum rate; if the doctor is accommodating this work in an un-contracted session.

4.3 Covering On call duties – ad hoc locum activity:
If a doctor is covering on call during the daytime, and is already in work, then no additional payment is made. If the doctor is covering during the daytime or out of hours, when they are on leave or un-contracted to work, then this activity is remunerated at the ad hoc locum rate.

4.4 A price cap has been applied for all Medical and Dental Ad hoc locum cover. These caps are the maximum payments allowed and are set out in table 2 below (rates are at November 2017 and will be subject to inflationary uplifts):

Table 2 – Capped rates for Ad Hoc Locum Cover

Grade and Shift	Cap hourly rate
Foundation Year 1	£32.54
Foundation Year 2	£40.36
Registrar (SP1-2)/Core Medical Training	£45.76
Registrar (SP3+)	£57.05
Dental Core Training	£56.15
Specialty Doctor/Staff Grade	£66.43
Associate Specialist	£82.21
Consultant	£97.22

4.5 The rate paid covers all costs but does not include employer's on-costs.

4.6 Where there is a requirement for any breaches of the cap rate for additional duty hours, payments must be authorised in advance by the Medical Director (or a nominated deputy).

4.7 As set out in the Welsh Amended Consultant Contract, in exceptional circumstances, where the Consultant is requested and agrees to be immediately available, i.e. 'resident on call', this will be remunerated at three times the sessional payment at Point 6 of the Consultant salary scale, excluding commitment awards and Clinical Excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day. For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends. This arrangement does not fall within WHC 2017/042.

All ADH claim forms (Annex A) must be authorised by the Directorate Manager and submitted to Payroll for payment.

5.0 WAITING LIST INITIATIVES

5.1 A Waiting List Initiative (WLI) is additional work that is agreed to be undertaken in order to support waiting lists and meet government targets. This activity is required to treat a 'backlog' of patients on a waiting list and achieve an improved waiting time.

5.2 The WLI rate is only applicable to medical & dental consultants in line with the Amendment to the Consultant Contract (Wales) 2003 and only when the activity is clearly defined as a WLI. The WLI rate applicable is £585 per session from 1 April 2017. The orthopaedics theatre WLI rate is currently £688 per session.

5.3 WLIs should only be agreed as additional sessions which are planned to specifically address waiting list challenges. They must not be agreed for backfilling core sessions.

5.4 Directorates must complete a WLI request form (Annex B) which includes , the number of planned sessions, ,duration and expected cost. This form must be authorised by the Directorate Manager in advance of the work being undertaken and this approval confirms that the directorate has a WLI budget for the expected cost. If a directorate does not have a WLI budget for the expected cost, the WLI request form should not be approved until a funding source and budget has been agreed.

5.5 All WLI claim forms (Annex C) must be completed by the doctor and approved by the [Directorate Manager] against the authorised WLI request form. This approval will also serve as the Manager's approval for payment.

5.6 Although not under the remit of the Medical & Dental terms & conditions, specialties have SAS doctors, or higher grade junior doctors (StH's), involved in WLI sessions, and these will be remunerated at a rate as agreed by the sub-specialty. This rate must be within the capped rate set out in Welsh Health Circular (WHC 2017-042). Refer to Table 2 above.

6.0 RECORDS MANAGEMENT

6.1 All payroll, authorisation and monitoring records will be:

a) Properly controlled
b) Readily accessible for use, and
c) Properly archived or otherwise disposed of

The actions taken to achieve the above should be in accordance with the NWSSP's and Health Board's Records Management Policy. These policies should be read in conjunction with other relevant FCPs.

7.0 EQUALITY IMPACT ASSESSMENT

7.1 Following assessment, this procedure is not felt to be discriminatory or detrimental in any way with regard to the following equality strands: Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human rights.

Cwm Taf University Health Board - ADH Form

Medical Staff Claim Form for Additional Duty Hour Payments

Full Name: _____ Payroll Number (essential for payment): _____

Pay Grade: _____ Specialty: _____ Directorate: _____ Site: _____

Please note all number of ADH's for Consultant, Associate Specialist & Specialty Doctors to be in sessions & Junior doctors to be in hours

Date Worked	Time Worked From	Time Worked To	Specialty Covered	Hospital	Reason for Absence	Covering Absence of & grade	No of ADH claimed: Hours	Rate of Payment	No of ADH claimed: Sessions	Rate of Payment
					Total ADH's claimed: (e.g. 5 sessions)		0		0	

I declare that I have performed the above duties outside my regular contractual commitment and that is why I am claiming additional payment.
I confirm that by working these additional shifts, my work pattern has not breached the rest break and rest perios requirements of the European Working Time Directive.

Signature of Claimant: _____ Date: _____

Signature of Directorate Booking Organiser or Authorising Consultant: _____ Date: _____

Please Complete: Expenditure Cost Centre Code: _____ (four digits) - Allowance code for Payroll - **"Extra Duty Allowance"**

Authorised by DM: _____ Print Name: _____ Date: _____

Cwm Taf University Health Board

Annex B

WLI Request & Payment Form

Medical Staff Claim Form for Authorisation & Payment of Waiting List Initiatives

Reason for Planned WLI: _____

Number of planned sessions	Date From	Date To	Rate of Payment	Total Cost
				£0.00

Requested and authorised by Directorate Manager:

I confirm the Directorate has the approved WLI funding for the anticipated expenditure noted above.
I confirm the planned WLI is not backfilling core sessions and will reduce the Directorate's waiting list.

Signature of DM: _____ Date: _____

Full Name: _____

Payroll Number (essential for payment): _____

Job Title: _____ Specialty: _____

Directorate: _____ Site: _____

Date Worked	Time Worked From:	Time Worked To:	Number of WLI sessions	Rate of Payment	Does this replace SPA Activity?

Total WLI's claimed: 0

Number of SPA sessions displaced: _____

I declare that I have performed the above duties outside my regular contractual commitment and that is why I am claiming additional payment.
If undertaking a WLI in what should be SPA time, I am claiming for the time period to which the SPA has been displaced.
I confirm that by working these additional shifts, my work pattern has not breached the rest break and rest perios requirements of the European Working Time Directive.

Signature of Claimant _____ Date: _____

Please Complete: Expenditure Cost Centre Code _____ (four digits)
Allowance code for Payroll - **"Waiting List Initiative"**

Authorised by DM: _____

Print Name: _____ Date: _____

Cwm Taf University Health Board

Rate of Payment
£585
£688

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 2.6** **1 April 2019**

Audit Committee Report
REVISED STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS (SFI's)

Executive Lead: Interim Board Secretary
Author: Interim Board Secretary
Contact details for further information: Gwenan Roberts 01443 744818 or Gwenan.Roberts@wales.nhs.uk

Purpose of the Audit Committee Report
The purpose of this report is to provide the Audit Committee with an update on the review of the Cwm Taf UHB's Standing Orders and to request that the Committee approve the proposed changes.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2018-2021, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	The Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 The Local Health Boards (Area Change) (Transfer of Staff, Property and Liabilities) (Wales) Order 2019

	NHS Wales Governance e-manual - NHS Trust Model Standing Orders Reservation & Delegation of Powers, Glossary of Terms and Model SFI's - March 2014[1]

Engagement – Who has been involved in this work?							
Chair of Audit Committee Interim Board Secretary							
Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**		**NOTE**	√
Recommendation	Members of the Audit Committee are asked to: • **NOTE** the amendments to the Board's Standing Orders • **ENDORSE** the updated Standing Orders and supporting Schedules and the changes to the Schedule of additional delegations linked to the Standing Financial Instructions (SFIs), for **APPROVAL** by the Board.						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	There are no known adverse implications of this report on equality & diversity. The Welsh Ministers' Code of Practice on the carrying out of Regulatory Impact Assessments was considered in relation to the new Regulations.
Legal implications	Welsh Government published model Standing Orders and Standing Financial Instructions for Local Health Boards (LHBs), following the enactment of the National Health Service Finance (Wales) Act 2014 and in line with the powers of direction in section 12 (3) of the National Health Service Wales Act 2006 and all Board's are required to incorporate and adopt the model SOs and SFIs into their own HB SOs and SFIs. As a consequence of the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 to recognise the Bridgend boundary change a number of changes were made to other statutory instruments: • the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009; • Welsh Health Specialised Services Committee (Wales) Regulations 2009;

[1] NHS Wales Governance e-manual - LHB Model Standing Orders, Reservation and Delegation of Powers and Model SFI's http://www.wales.nhs.uk/governance-emanual/standing-orders-local-health-boards

	• the Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010; • to the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010; • the Mental Health (Regional Provision) (Wales) Regulations 2012; • the Emergency Ambulance Services Committee (Wales) Regulations 2014; • the Safeguarding Boards (General) (Wales) Regulations 2015;
Population Health	No impact
Quality, Safety & Patient Experience	Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Resources	The SO's are supported by the Standard Financial Instructions (SFI's) which are based on the Welsh Government model SFI's which are currently being reviewed by the Deputy Directors of Finance Governance work stream. The Local Health Boards (Area Change) (Transfer of Staff, Property and Liabilities) (Wales) Order 2019 governs the arrangements for the transfer of staff, rights and responsibilities, property, information, data and records, investigation of outstanding complaints and continuity in the exercise of functions.
Risks and Assurance	The adoption of Standing Orders and Standing Financial Instructions is a key element of the corporate governance arrangements of the Board. The adoption of the model in place ensures compliance with Welsh Government directives and guidance and ensures consistency across NHS Wales. There are significant risks to the organisation if arrangements are not in place outlining accountabilities and delegated responsibilities to Officer Members of the Board.
Health & Care Standards	The Standing Orders and accompanying documents ensure that there are effective governance procedures in place and demonstrates compliance with the governance, leadership and accountability overarching principle of the quality themes outlined in the Health and Care Standards 2015.
Workforce	The Local Health Boards (Area Change) (Transfer of Staff, Property and Liabilities) (Wales) Order 2019 governs the arrangements for the transfer of staff, rights and responsibilities, property, information, data and records, investigation of outstanding complaints and continuity in the exercise of functions.
Freedom of Information Status	Open

REVISED STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS (SFI's)

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide an update to the Audit Committee following review of the Health Board's Standing Orders and Standing Financial Instructions (SFI's).

Once the Audit Committee have reviewed and approved the revisions the updated documents will be submitted to the Board with a recommendation to approve.

2. BACKGROUND / INTRODUCTION

The Welsh Government reissued new model Standing Orders (SOs) and Standing Financial Instructions (SFIs) for Local Health Boards (LHBs) on 27 March 2014. The National Health Service Finance (Wales) Act 2014 changed the duties of Local Health Boards to provide a rolling three-year financial duty and a requirement to prepare a plan that complies with that duty.

The Standing Orders were last reviewed and approved by the Audit Committee on the 16 April 2018 and were approved at the Board meeting held on the 31 May 2018.

To ensure effective governance for the Cwm Taf UHB, the standing orders are reviewed on an annual basis. The Standing Orders document has not changed significantly from previous versions and a summary of the amendments proposed is presented at **Appendix 1** for approval. The main focus of the review has been to ensure that the Standing Orders reflect the governance changes following the Bridgend Transition Programme, when responsibility for the providing health services for the geographical area of Bridgend transfer from Abertawe Bro Morgannwg UHB to Cwm Taf UHB on the 1 April 2019, and to reflect the new Health Board name "Cwm Taf Morgannwg University Health Board (CTMUHB)".

The full updated Standing Orders and accompanying documents are presented at **Appendix 2 a-j** (hard copies will be provided on request only). Note that the terms of reference for Committees and advisory groups will be updated in line with the compilation of the Annual report 2018-2019.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Section 10 of the Cwm Taf UHB standing order states that:

11.0.1 These SOs shall be reviewed annually by the Audit Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the equality impact assessment.

The annual revision of the document is a key element of the corporate governance arrangements of the Cwm Taf UHB and provides assurance that the SOs are compliant with Welsh Government directives and model standing orders, is up to date with emerging legislation and regulatory guidance and ensures consistency in managing the business of Committee.

The Standing Orders and SFIs specify certain key responsibilities of the Chief Executive Officer (CEO), the Director of Finance & Procurement and other officers of the Board. The CEO's job description, together with the Accountable Officer Memorandum sets out the specific responsibilities, and the individual job descriptions determined for Director level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, together with the associated financial delegations set out in the SFIs plus any agreed additional delegations form the basis of the Health Board Scheme of Delegation to Officers.

The Welsh Government are in the process of reviewing the model Standing orders for Health Boards and an updated model will be published in 2019.

Declarations of Interest

In line with the Standing Orders, the Corporate Services team have started the process for capturing declarations of interest; this has been completed for Board Members.

Standing orders state:
'*Declaration of interests* – It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business'.

The Standards of Behaviour Policy also requires that the following complete declarations of interest:

Independent & Associate Members	Annually in January
Executive Directors	Annually in January
Clinical Directors, Directorate Managers and Heads of Nursing	Annually in March
Assistant Directors, Heads of Corporate Departments and all managers or staff at Band 8a and above	Annually in March
Senior Finance and Procurement Employees	Annually in March
Consultants and Senior Clinical Staff	Annually in March

Members will recall approving the Standards of Behaviour Policy in January which included information for staff to explain that the information provided would be publicised on the website and reported to the Audit Committee.

Work is progressing on capturing the Declarations of Interest, all relevant staff received an email at the end of February to complete their form on SharePoint in March. A further reminder email has also been sent. During April, the information received will be shared with the Directorate management team for the Clinical Business Meetings and the Directorates will be responsible for ensuring that their staff are compliant with the policy.

4. RECOMMENDATIONS

Members of the Audit Committee are asked to:

- **NOTE** the amendments to the Board's Standing Orders; and
- **ENDORSE** the updated Standing Orders and supporting Schedules and the changes to the Schedule of additional delegations linked to the Standing Financial Instructions (SFIs), for **APPROVAL** by the Board.

Freedom of Information Status	Open

Appendix 1

Summary of the Revisions to the Cwm Taf UHB Standing Orders & Standing Financial Instructions (SFI's)

Doc/Page number	Amendment
Revised Standing Orders and Scheme of Financial Delegation	
Various	**References & Grammar** Minor housekeeping amendments, including: • changing Cabinet Secretary for Health and Social Care to Minister for Health and Social Services.
Page 1	**Change of Name/Corporate Logo** Changing Cwm Taf University Health Board (CTUHB) to Cwm Taf Morgannwg University Health Board (CTMUHB). New corporate logo to reflect the new corporate identity as Cwm Taf Morgannwg UHB.
Page 2 Page 8	**Legislative Changes** The foreword has been updated to include reference to the legislative changes that were made to legally sanction the transfer of responsibility or Bridgend to Cwm Taf UHB. **The Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019** This Order changes the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changes their names. The principal local government area of Bridgend is transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board. Abertawe Bro Morgannwg University Local Health Board is renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board is renamed Cwm Taf Morgannwg University Local Health Board. Amendments giving effect to these changes are made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. Changes to local health board areas have the effect of changing the area of the relevant Community Health Councils. Accordingly, this Order amends the Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010 to reflect the changes in local health board areas.

	In addition, Cwm Taf Community Health Council is renamed Cwm Taf Morgannwg Community Health Council and Abertawe Bro Morgannwg Community Health Council is renamed Swansea Bay Community Health Council. Amendments are also made to the number of members of those Councils. This Order also makes amendments to other statutory instruments arising from the changes described above.
Page 11	**NHS Framework** Additional reference to Well-being of Future Generations (Wales) Act 2015.
1.1.4 Page 16	**Non Officer Members [known as Independent Members]** Total number of non-officer members changed from 9 to 10 to reflect the additional Associate Board Member to represent Bridgend County Borough Council (BCBC) following the Bridgend Transition Programme.
2.0.7 Page 23	**RESERVATION AND DELEGATION OF LHB FUNCTIONS** Reference to the newly established special health authority "Health, Education and Improvement Wales (HEIW)" has been included. Health Education and Improvement Wales (HEIW) is a Special Health Authority (SHA) that was established on 05 October 2017 and became operational on the 01 October 2018, following a six month period in shadow form under The Health Education and Improvement Wales (Establishment and Constitution) Order 2017 (SI No. 913 (W. 224)) "the Establishment Order". Section 72 of the NHS Act 2006 places a duty on NHS bodies, including an SHA to co-operate with each other in exercising their functions. Section 82 of the NHS Act 2006 places a duty on NHS.
6.2.5 6.3 6.5.16 Page 52 & 56	**Annual General Meeting (AGM),** **Calling Meetings &** **Proposing a formal notice of motion** Clarification that reference to "days" refers to calendar days, e.g. Public notice of the intention to hold the AGM shall be given at least 10 calendar days prior to the meeting
Schedule 1a	**<u>Scheme of Reservation and Delegation of Powers</u>** Minor housekeeping amendments and added the following: Page 13

	Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.
Schedule 1b	**Additional Delegations Linked to the Standing Financial Instructions** Minor housekeeping amendments This will need to be amended when the new management structures are agreed for Cwm Taf Morgannwg UHB – this should take place as soon as the structures are finalised expected to be in the Summer.
Schedule 2	**Key Guidance, Instructions and Other Related Documents** Links to The Good Governance Guide for NHS Wales Boards
Schedule 3	**Board Committee Arrangements** Each Committee's Terms of reference are in the process of being updated formally through the individual Committees and will be updated and will be received by the Board with Committee Annual Reports during the Summer months.
Schedule 4	**Joint Committee Arrangements** No changes
Schedule 5	**Advisory Groups** Each Advisory Group's Terms of Reference are in the process of being updated formally through the individual groups and will be updated and will be received and approved by Board alongside the annual reports.
Schedule 6	**Glossary of Terms** Minor amendments to include NWSSP and HEIW.
Schedule 7	**Code of Conduct and Accountability for NHS Boards (2006)** **No amendments.**
Schedule 8	**Committee Chairs and Champions** Updated to reflect the new Independent Members and their related Champion roles.

All of the Schedules have been reviewed and updated where required and are published on the Cwm Taf UHB website with the Audit Committee papers. An Equality Impact Assessment is also included.

Standing Orders

Reservation and Delegation of Powers

For the

Cwm Taf Morgannwg Morgannwg University Health Board (UHB)

Originally Introduced May 2014

(Updated April 2019)

Initiated by:	Board Secretary/Director of Corporate Services and Governance
Date approved:	1 April 2019
Approved by:	Health Board
Review date:	March 2020
Version:	Nine
Responsible Director:	Board Secretary/Director of Corporate Services and Governance
Distribution:	All staff via the intranet site Chair Vice Chair Independent Members Associate Members Executive Directors
FOI Status:	Open

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12(3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

In April 2019 these standing orders were updated to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changes the areas of Cwm Taf Morgannwg University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changes their names.

The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board is renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board is renamed Cwm Taf Morgannwg Morgannwg University Health Board. The Amendments giving effect to these changes are made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.

These documents form the basis upon which the UHB's governance and accountability framework is developed and, together with the adoption of

the UHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All UHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the UHB.

Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

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Section A – Introduction

Statutory framework

i) The Cwm Taf Local Health Board (the UHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009 / 778 (W.66)**, "the Establishment Order". The Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board is renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009.

ii) The principal place of business of the UHB is Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN.

iii) All business shall be conducted in the name of Cwm Taf Morgannwg LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)** ("The Constitution

Regulations") which set out the constitution and membership arrangements of LHBs. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511 (W.147).**

vi) However, in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

vii) The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("the Joint Committee"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097 (W.270) which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements.

viii) The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) (the EASC Directions) provide that the seven LHB's in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services. The Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each HB in Wales. The Joint Committee is hosted by the Cwm Taf Morgannwg UHB on behalf of each of the seven HBs.

ix) In December 2015, the Welsh Ministers directed the Health Boards under the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8)1 to be responsible for commissioning Non-Emergency Patient Transport (NEPT) services via the Emergency Ambulance Services Committee from April 2016.

x) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function.

xi) As a statutory body, the LHB has specified powers to contract in its

1 the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8)
http://www.wales.nhs.uk/sitesplus/documents/1134/2016%20No%208%20%28W8%29%20The%20EASC%20%28Wales%29%20%28Amendment%29%20Directions%202016.pdf

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

xii) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993 (W.193))** made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the health improvement plan of the relevant health plan.

xiii) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

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

xv) The Welsh Language (Wales) Measure 2011 and the Welsh Language (Health Sector) Regulations 2016 place a duty on public bodies to implement a Welsh Language Scheme which outlines how the LHB will comply with its statutory responsibility to provide services through the medium of Welsh. The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language which replaced the original system of Welsh Language Schemes provided for by the Welsh Language Act.

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

xvii) LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

NHS Framework

xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

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

xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xxi) The Welsh Ministers, reflecting their constitutional obligations, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does. The Well-being of Future Generations (Wales) Act 2015 explains what is meant by sustainable development and requires bodies that are designated as 'public bodies' under section 6 of the 2015 Act to set well-being objectives and contribute to the achievement of well-being goals.

xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.nhs.wales.uk/governance-emanual/ Directions or guidance on specific aspects of LHB business are also issued in hard copy, usually under cover of a Ministerial letter.

Local Health Board Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with

these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

xxiv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Cwm Taf Morgannwg LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

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

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

Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on Committees may be found in Schedule 3 of these SOs*.

xxviii) Full details of any non compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxix) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 6.5.14 has been given.

Interpretation

xxx) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

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

The role of the Board Secretary

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

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;

- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

xxxiii) As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair [and Chief Executive], and reports on a day to day basis to the Chief Executive.

xxxiv) Further details on the role of the Board Secretary within Cwm Taf Morgannwg LHB, including details on how to contact them, are available at:

http://www.cwmtafuhb.wales.nhs.uk/robert-williams

Mr Robert Williams
Board Secretary and Director of Corporate Services and Governance
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Additional information

During July 2013, the Minister for Health and Social Services announced University status for Cwm Taf Morgannwg UHB which commenced in October 2013 and following assessment of related progress, was re-awarded in 2017.

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.1.1 The LHB shall embed Cwm Taf Morgannwg UHB's strategic objectives and priorities through the conduct of its business and in so doing, and in transacting its business, shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act, the Welsh Government Guidance on Ethical Procurement and the Code of Practice on ethical employment in supply chains.

1.1.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778 (W.66)) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511 (W.147)). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

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

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 20 members comprising the Chair and the Vice Chair (both appointed by the Minister for Health and Social Services), the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer and non officer members.

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights. There may also be Associate Members who do not have voting rights.

Officer Members [Known as Executive Directors]

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

Non Officer Members [known as Independent Members]

1.1.4 A total of **9 (Gwen – is the representative from Bridgend CBC now attending making this 10?),** appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

Associate Members

1.1.5 The following Associate Members, appointed by the Minister for Health and Social Services, will attend Board meetings on an ex-officio basis, but will not have any voting rights:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.6 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

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

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i Either or both persons may attend and take part in Board meetings;
ii If both are present at a meeting they shall cast one vote if they agree;
iii In the case of disagreement no vote shall be cast; and
iv The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year, with a maximum term of four years if re-appointed.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

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

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

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of

strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.10 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.11 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

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

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Schedule of matters reserved to the Board;
ii Scheme of delegation to committees and others; and
iii Scheme of delegation to officers.

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

2.0.3 Subject to Standing Order 2.0.4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf. Where LHBs have a joint duty, e.g. to produce a Health, Social Care and Well Being Strategy or for the provision of Shared/Hosted Services, the LHB remains fully responsible for its part, and shall agree through the determination of a written Partnership Agreement the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.0.4 **NHS Wales Shared Services Partnership (NWSSP)**

Background Information

In 2011 the NHS bodies in Wales, together with the Welsh Assembly Government (as it then was) decided to bring together various support services functions across the NHS in Wales under a single management team as a "virtual" Shared Services entity.

In September 2011 the Welsh Ministers gave authority to proceed with the transfer of responsibility for the provision of Shared Services from the virtual model to a body hosted within NHS Wales.

Following an invitation to all NHS bodies to express an interest in becoming the host organisation, Velindre NHS Trust was confirmed as the host organisation on 22nd November 2011.

Arrangements from 1st June 2012

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

The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations prescribe the membership of the Shared Services Partnership Committee in order to ensure that all LHBs and Trusts in Wales have a member on the Shared Services Partnership Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

The Managing Director of Shared Services will be designated as

Accountable officer for Shared Services.

These new arrangements also necessitate putting in place a new Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Partnership Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

2.0.5 **Welsh Health Specialised Services Committee (WHSSC)**

Background Information

The Welsh Health Specialised Services Committee (WHSSC) was established in 2010 by the seven Local Health Boards in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services. In establishing WHSSC to work on their behalf, the seven Local Health Boards (LHBs) recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

Arrangements from 2009

The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("the Joint Committee"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097 (W.270) which make provision for the constitution and membership of the Joint Committee including its procedures and administrative arrangements**.**

The Managing Director of WHSCC will be designated as Accountable officer for the WHSCC.

These arrangements also necessitate putting in place a new Memorandum of Co-operation Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the

Welsh Health Specialised Services Committee and to take collective responsibility for setting the policy, planning and securing of specialised and tertiary services to the health service in Wales. A Hosting Agreement will be put in place with Cwm Taf Morgannwg UHB and responsibility for the exercise of the WHSCC functions will not rest with the Board of Cwm Taf Morgannwg UHB but will be a shared responsibility of all NHS bodies in Wales.

2.0.6 **Emergency Ambulance Services Committee (EASC)**

Background Information

The Emergency Ambulance Services Committee (EASC) was established in 2014 by the seven Local Health Boards in Wales. In establishing the Emergency Ambulance Services Joint Committee (EASC) to work on their behalf, the seven Local Health Boards (LHBs) recognised that the most efficient and effective way of planning services was to work together to reduce duplication and ensure consistency.

The Emergency Ambulance Services Committee (EASC) (Wales) Regulations 2014 (SI 2014 No.566 (W.67)[2] make provision for the constitution of the "Joint Committee" including its procedures and administrative arrangements.

In December 2015, the Welsh Ministers directed the Health Boards under the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8)3 to be responsible for commissioning Non-Emergency Patient Transport (NEPT) services via the Emergency Ambulance Services Committee from April 2016.

The Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each HB in Wales, established under the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) (the EASC Directions). The functions and services of the Joint Committee are listed in the EASC Directions and are subject to variations to those functions agreed from time to time by the Joint Committee. The Joint Committee is hosted by the Cwm Taf Morgannwg UHB on behalf of each of the seven HBs.

The Chief Ambulance Services Commissioner (CASC) is designated as Accountable officer for the EASC.

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2 The Emergency Ambulance Services Committee (EASC) (Wales) Regulations 2014 (SI 2014 No.566 (W.67)2http://www.wales.nhs.uk/sitesplus/documents/1134/Welsh%20Statutory%20Instrument%20for%20EASC%202014%20No%20566%20%28w67%29.pdf

3 the EASC (Wales) (Amendment) Directions 2016 No.8 (W.8) http://www.wales.nhs.uk/sitesplus/documents/1134/2016%20No%208%20%28W8%29%20The%20EASC%20%28Wales%29%20%28Amendment%29%20Directions%202016.pdf

These arrangements also necessitate putting in place a Memorandum of Co-operation Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Emergency Ambulance Services Committee (EASC) and to take collective responsibility for setting the policy, planning and securing of Emergency and Non-Emergency Ambulance Services to the health service in Wales. A Hosting Agreement is in place with Cwm Taf Morgannwg UHB and responsibility for the exercise of the EASC functions will not rest with the Board of Cwm Taf Morgannwg UHB but will be a shared responsibility of all NHS bodies in Wales.

2.0.7 **Health, Education and Improvement Wales (HEIW)**

Background Information

Health Education and Improvement Wales (HEIW) is a Special Health Authority (SHA) that was established on 05 October 2017 and became operational on the 01 October 2018, following a six month period in shadow form under The Health Education and Improvement Wales (Establishment and Constitution) Order 2017[4] (SI No. 913 (W. 224)) "the Establishment Order". Section 72 of the NHS Act 2006 places a duty on NHS bodies, including an SHA to co-operate with each other in exercising their functions. Section 82 of the NHS Act 2006 places a duty on NHS bodies, including an SHA, and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

2.1 Chair's action on urgent matters

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

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

4 The Health Education and Improvement Wales (Establishment and Constitution) Order 2017
http://www.legislation.gov.uk/wsi/2017/913/contents/made

2.2 Delegation of Board functions

2.2.1 The Board shall agree the delegation of any of their functions to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

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

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

2.3 Delegation to officers

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

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

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

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to

openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

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

- Board Committee
- joint-Committee
- sub-Committee
- joint sub-Committee

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

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.3 Sub-Committees

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

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish

Committees which cover the following aspects of Board business:

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

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

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

Cwm Taf Morgannwg University Health Board will establish the following Committees and the detailed terms of reference for each of these Committees are set out in Schedule 3: -

- Academic Partnership Board
- Audit Committee
- Charitable Funds Committee
- Finance, Performance & Workforce Committee
- Integrated Governance Committee
- Mental Health Act Monitoring Committee
- Primary Care & Community Committee
- Quality & Safety & Risk Committee
- Remuneration & Terms of Service Committee

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

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

aspects to the minimum necessary. *Detailed terms of reference and operating arrangements for the Committees established by the Board are set out in Schedule 3.*

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not normally be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

3.5 Joint Committees established by the LHB

3.5.1 The LHB has a duty to co-operate with other NHS bodies in exercising its functions, and with local authorities in order to secure and advance the health and welfare of its citizens. To help discharge these duties and meet the Board's commitment to working in partnership, the Board may and, where directed by the Welsh Ministers must, establish joint-Committees to support it in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.5.2 The Board shall establish, as a minimum, the following joint-Committees:

- The Welsh Health Specialised Services Committee (WHSSC)
- The Emergency Ambulance Services Committee (EASC)

Joint Committee Standing Orders, terms of reference and operating arrangements

3.5.3 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established.

These must establish its governance and ways of working, setting out, as a minimum:

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

3.5.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.6 Other Committees

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

3.7 Confidentiality

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

3.8 Reporting activity to the Board

3.8.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. ADVISORY GROUPS

4.0.1 The LHB has a statutory duty to take account of representations made by persons who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers

must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

4.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

4.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

4.1 Confidentiality

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

4.2 Reporting activity

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

4.2.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

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

4.3 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

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

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

consultation; as well as

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

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

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

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

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

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

4.4 Terms of reference and operating arrangements

4.4.1 The Board must formally approve terms of reference and operating arrangements for the SRG**.** These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as community partnerships such as Local Service Boards;

- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

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

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

4.5 Membership

4.5.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

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

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

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

- Demography of the areas served by the LHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the LHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or

geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the LHB at local community levels;
- Need to complement, and not duplicate the work of CHCs; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

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

4.6 Member Responsibilities and Accountability:

The Chair

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

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

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

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

The Vice Chair

4.6.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

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

Members

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

4.6.7 All members must:

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

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

4.7 Appointment and terms of office

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

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

4.7.3 Members shall be appointed for a period specified by the Board, but

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

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

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

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

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

4.7.8 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is

reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

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

4.8 Resignation, suspension and removal of members

4.8.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

4.8.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

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

4.8.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

4.8.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and
ii The person will be able to attend such meetings within such period as the Board considers reasonable.

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

4.9 Relationship with the Board

4.9.1 The SRG's main link with the Board is through the SRG Chair's

membership of the Board as an Associate Member.

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

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

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

4.10 Relationship between the SRG and others

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

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

4.11 Working with Community Health Councils

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

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

4.12 Support to the SRG

4.12.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the SRG is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the SRG;
- Co-ordinating and facilitating appropriate induction and organisational development activity;

- Ensuring the provision of governance advice and support to the SRG Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for SRG meetings;
- Ensuring that the SRG receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups; and
- Facilitating effective reporting to the Board

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

4.13 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

4.13.1 The HPF's role is to provide a balanced, multi disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

4.13.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

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

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

4.14 Terms of reference and operating arrangements

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

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountability, and terms and

conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others, (including the LHB Board, its Committees and Advisory Groups) as well as the National Professional Advisory Group;
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements

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

4.14.3 The Board may determine that the HPF shall be supported by a range of sub-fora to assist it in the conduct of its work, e.g. special interest groups, or the HPF may itself determine such arrangements, provided that the Board approves such action.

4.15 Membership

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

- Welsh Medical Committee
  - Primary and Community Care Medical representative
  - Mental Health Medical representative
  - Specialist and Tertiary Care medical representative

- Welsh Nursing and Midwifery Committee
  - Community Nursing and Midwifery representative
  - Hospital Nursing and Midwifery representative

- Welsh Therapies Advisory Committee
  - Therapies representative

- Welsh Scientific Advisory Committee
  - Scientific representative

- Welsh Optometric Committee
  - Optometry representative

- Welsh Dental Committee
  - Dental representative

- Welsh Pharmaceutical Committee
  - Hospital Pharmacists representative
  - Community Pharmacists representative

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

4.16 Member Responsibilities and Accountability:

The Chair

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

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

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

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

The Vice Chair

4.16.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the LHB Board.

4.16.5 The Vice Chair is accountable through the HPF Chair to the LHB Board for their performance as Vice Chair, and to their

nominating body or grouping for the way in which they represent their views at the HPF.

Members

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

4.16.7 All members must:

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

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

4.17 Appointment and terms of office

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

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

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

4.17.4 The ***Vice Chair*** will be nominated from within the membership of the HPF, by its members, in a manner determined by the Board, subject to the condition that they be appointed from a different healthcare discipline to that of the Chair, along with any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the HPF Chair's absence, the Vice Chair will also perform the role of Associate Member on the LHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

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

4.17.6 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the HPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The HPF Chair will advise the Board in writing of any such cases immediately.

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

4.18 Resignation, suspension and removal of members

4.18.1 A member of the HPF may resign office at any time during the period of appointment by giving notice in writing to the HPF Chair and the Board.

4.18.2 If the Board, having consulted with the HPF Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the HPF that a person should continue to hold office as a member; or

- It is not conducive to the effective operation of the HPF

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

4.18.3 A nominating body or group may request the removal of a member appointed to the HPF to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

4.18.4 If a member fails to attend any meeting of the HPF for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

i The absence was due to a reasonable cause; and
ii The person will be able to attend such meetings within such period as the Board considers reasonable.

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

4.19 Relationship with the Board

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

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

4.19.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

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

4.20 Rights of Access to the LHB Board for Professional Groups

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

circumstances:

i Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g. due to the specialist nature of the issues concerned; or

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

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

4.21 Relationship with the National Professional Advisory Group

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

4.22 Support to the HPF

4.22.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the HPF is properly equipped to carry out its role by:

- co-ordinating and facilitating any appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the HPF Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Forum meetings;
- Ensuring that the HPF receives the information it needs on a timely basis; and
- Facilitating effective reporting to the Board

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

4.23 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

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

LHB's workforce. The LPF will be known as the 'Working in Partnership Forum' in Cwm Taf Morgannwg University Health Board.

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

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

- In written advice; or
- In any other form specified by the Board.

4.24 Terms of reference and operating arrangements

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

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

4.24.2 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the Trade Union Congress (TUC) six principles of partnership working. The detailed terms of reference and operating arrangements are set out in Schedule 5.1.

4.24.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on

service and operational management issues specific to Divisions/Directorates/Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

4.25 Membership

4.25.1 The LHB shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

Management Representatives

- LHB Chief Executive
- Director of Finance
- Director of Workforce and Organisational Development

together with the following

- General Managers
- Workforce and Organisational Development staff

4.25.2 The LHB may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

Staff Representatives

4.25.3 The maximum number of staff representatives shall be agreed within the terms of reference comprising representation from those staff organisations recognised by the LHB.

In attendance

4.25.4 The Trade Union member of the LHB Board shall attend LPF meetings in an ex officio capacity.

4.25.5 The LPF may determine that full time officers from those staff organisations recognised by the LHB shall be invited to attend LPF meetings

4.26 Member Responsibilities and Accountability

Joint Chairs

4.26.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.26.2 The Chairs shall be jointly responsible for the effective

operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the LHB's Board.

4.26.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the LHB's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.26.4 The Chairs are accountable to the LHB Board for the conduct of business in accordance with the governance and operating framework set by the LHB.

Joint Vice Chairs

4.26.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.26.6 Each Vice Chair shall deputise for their Chair in that Chairs absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.26.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

4.26.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.26.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and

- Promote the work of the LPF within the professional discipline they represent.

4.27 Appointment and terms of office

4.27.1 Management representative members shall be determined by the LHB Board.

4.27.2 Staff representatives shall be determined by the staff organisations recognised by the LHB, subject to the following conditions:

- Staff representatives must be employed by the LHB and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by the LHB or cease to be a member of their nominating trade union.

4.27.3 The *Management Representative Chair* shall be appointed by the LHB Board.

4.27.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.27.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.27.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.27.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.28 Removal, suspension and replacement of members

4.28.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.28.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

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

4.28.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.29 Relationship with the Board and others

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

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

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

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

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

4.30 Support to the LPF

4.30.1 The LPF's work shall be supported by two designated Secretary's, one of whom shall support the staff representative members and one shall support the management representative members.

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

4.30.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.30.4 Both Secretaries shall work closely with the LHB's Board Secretary who is responsible for the overall planning and co-ordination of the LHB's programme of Board business, including that of its Committees and Advisory Groups.

5. WORKING IN PARTNERSHIP

5.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g. the development of Health, Social Care and Well Being Strategies.

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

- The LHB's own structures and operating arrangements, e.g. Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Local Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

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

5.1 Community Health Councils (CHCs)

5.1.1 The **Community Health Councils Regulations 2004** (S.I. 2004/905 (W.89)) (as amended by the **Community Health Councils (Amendment) Regulations 2005** (S.I. 2005/603 W.51)) (to the extent they are still in force), the **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288 (W.37)) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289 (W.38)) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

5.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the LHB's area by ensuring their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for

and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is responsible for.

5.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

5.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.

5.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.

5.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Equality Act 2010, Welsh Language (Wales) Measure 2011 as well as its Communication Strategy.

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

6.2 Annual Plan of Board Business

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

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

6.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned

activities of the Board's Committees and Advisory Groups.

6.2.4 The Board shall agree the plan for the forthcoming year by the end of March and this plan will be included as a schedule to these SOs.

Annual General Meeting (AGM)

6.2.5 The LHB must hold an AGM in public no later than the 30th September each year. Public notice of the intention to hold the AGM shall be given at least 10 calendar days prior to the meeting, and this notice shall also be made available through community and partnership networks to maximise opportunities for attendance. The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others, such as the LHB's annual Equality Report. A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

6.3 Calling Meetings

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

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

6.4 Preparing for Meetings

Setting the agenda

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

6.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public

and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

6.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least one calendar week before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. Equality impact assessments (EIA) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that EIA shall accompany the report to the Board to enable the Board to make an informed decision.

6.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with Standing Order 6.3, at least one calendar week before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- At the LHB's principal sites;
- On the LHB's website, together with the papers supporting the public part of the Agenda; as well as

- Through other methods of communication as set out in the LHB's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.5 Conducting Board Meetings

Admission of the public, the press and other observers

6.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility such as an induction loop system.

6.5.2 The Board shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

6.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

6.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are

welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Receipt of Petitions

6.5.7 The Board Secretary will ensure that the Board is advised of any petitions containing more than 100 signatures that are received at the Health Board Headquarters.

Addressing the Board, its Committees and Advisory Groups

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

Chairing Board Meetings

6.5.9 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.5.10 Where the Chair of the Board has died or has ceased to hold office, or where he / she has been unable to perform his / her duties as Chair owing to illness, absence from England and Wales or any other cause, the Vice Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his / her duties, as the case may be. References to the Chair in these Standing Orders shall, as long as there is no Chair able to perform his / her duties, be taken to include reference to the Vice Chair.

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

Quorum

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

6.5.13 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g. a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.5.14 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

6.5.15 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

6.5.16 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.17 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

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

6.5.19 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.5.20 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.21 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.22 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and

the Chair.

6.5.23 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

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

Voting

6.5.25 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

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

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

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

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with

apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act 1998, and the LHB's Communication Strategy and Welsh language requirements.

6.7 Confidentiality

6.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board will form part of these SOs.

7.1 Declaring and recording Board members' interests

7.1.1 ***Declaration of interests*** **–** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the Constitution Regulations. Board members must notify the Board of any such interests at the time of their appointment, and any further interests as they arise

throughout their tenure as Board members.

7.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

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

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

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

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

7.2 Dealing with Members' interests during Board meetings

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

7.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda,

that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

7.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

ii The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

iii The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

iv The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

7.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

7.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[5] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

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

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

7.3 Dealing with officers' interests

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

7.4 Reviewing how Interests are handled

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

7.5 Dealing with offers of gifts[6] and hospitality

7.5.1 The Values and Standards of Behaviour Framework adopted by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

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

[6] The term gift refers also to any reward or benefit.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, and sport, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

7.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches,

lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Register of Gifts and Hospitality

7.6.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts and Hospitality to record offers of gifts and hospitality made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

7.6.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts and hospitality are kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the Register, individuals shall apply the following principles, subject to the considerations in Standing Order 7.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g. seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[7]' hospitality need not be included in the Register.

7.6.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The Board Secretary will arrange for a full report of all offers of Gifts and Hospitality recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the

[7] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

LHB's arrangements for dealing with offers of gifts and hospitality.

8. SIGNING AND SEALING DOCUMENTS

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

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

8.1 Register of Sealing

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

8.2 Signature of Documents

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

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

8.3 Custody of Seal

8.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

9. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

9.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly

the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

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

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

9.0.4 Assurances in respect of the Welsh Health Specialised Services Committee (WHSCC) shall primarily be achieved by the reports of the Managing Director of WHSCC to the Joint Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Managing Director of WHSCC. The Managing Director of WHSCC and the Joint Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

9.0.5 Assurances in respect of the Emergency Ambulance Services Committee (EASC) shall primarily be achieved by the reports of the Chief Ambulance Services Commissioner (CASC) to the Joint Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the CASC of EASC. The CASC of EASC and the Joint Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

9.1 The role of Internal Audit in providing independent internal assurance

9.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

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

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

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

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

9.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 3 months of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

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

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

9.3 External Assurance

9.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g. the Wales Audit Office and Healthcare Inspectorate Wales.

9.3.2 The Board may be assured, from the work carried out by external

audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

9.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the National Assembly for Wales's Audit Committee, the Public Accounts Committee or other appropriate bodies.

9.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Schedule 8 of the Government of Wales Act 2006 (c.42).

10. DEMONSTRATING ACCOUNTABILITY

10.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

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

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

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

11. REVIEW OF STANDING ORDERS

11.0.1 The SOs have been subject to an equality impact assessment

and no impact has been identified.

11.0.2 These SOs shall be reviewed annually by the Audit Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the equality impact assessment.

SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the UHB may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. The Board may delegate functions to:

i) a Committee, e.g. Quality, Safety & Risk Committee;

ii) a sub-Committee, e.g. a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Boards authority, usually be via a main Committee of the Board;

iii) a joint-Committee or joint sub-Committee, e.g. with other Health Boards established to take forward matters relating to specialist services;

iv) Officers of the UHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the UHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others;
- Scheme of delegation to Officers.

all of which form part of the UHB Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in Standing Orders or Standing Financial Instructions

- The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management

- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility

- The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development

- The Board must take appropriate action to assure itself that all matters delegated are effectively carried out
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes
- Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others
- The Board may delegate authority to act, but retains overall responsibility and accountability
- When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

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

- the guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)

- their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

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

The Director of Corporate Services and Governance / Board Secretary

The Director of Corporate Services and Governance / Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- a proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;

- effective arrangements are in place for the delegation of UHB functions within the organisation and to others, as appropriate; and

- arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:
- equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity;

- exercising any powers delegated to them in a manner that accords with the UHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Director of Governance and Corporate Services / Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

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

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g. to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the UHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the UHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with Standing Orders[1]
2	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the UHB, including standards/requirements determined by professional bodies/others, e.g. Royal Colleges
3	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ Standing Orders; ▪ Schedule of matters reserved to the UHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to Officers. In accordance with any directions set by the Welsh Ministers.
4	FULL	OPERATING ARRANGEMENTS	Approve the UHB's framework for performance management, risk and assurance
5	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the UHB's aims, objectives and priorities
6	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
7	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with Standing Orders
8	FULL	OPERATING ARRANGEMENTS	Approve policies for dealing with complaints, legal claims and incidents
9	FULL	OPERATING ARRANGEMENTS	Authorise use of the UHB's official seal
10	FULL	ORGANISATION STRUCTURE & STAFFING	Ratify appointment and manage appraisal, discipline and dismissal of the Chief Executive
11	R&TS Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, remuneration, appraisal, discipline and dismissal of Executive Directors and any other Board level appointments, e.g. the Director of Corporate Services and Governance / Board Secretary
12	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. from Audit Committee
13	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the UHB's top level organisation structure and corporate policies
14	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Board Committees, including any joint-Committees directly accountable to the Board
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
17	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the UHB's responsibilities as a corporate trustee for funds held on trust
19	FULL	STRATEGY & PLANNING	Determine the UHB's strategic aims, objectives and priorities
20	FULL	STRATEGY & PLANNING	Approve the UHB's Integrated Medium Term Plan (IMTP), including the balanced Medium Term Financial Plan
21	FULL	STRATEGY & PLANNING	Approve the UHB's Risk Management Strategy and plans
22	FULL	STRATEGY & PLANNING	Approve the UHB's Communication Strategy including its citizen engagement and involvement strategy
23	FULL	STRATEGY & PLANNING	Approve the UHB's partnership and stakeholder engagement and involvement strategies
24	FULL	STRATEGY & PLANNING	Approve the UHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient centred clinical services for their population ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM & T, Estates and Capital (including major capital investment and disposal plans)
25	FULL	STRATEGY & PLANNING	Approve the UHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
26	FULL	STRATEGY & PLANNING	Approve new contracts for the UHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the UHB's population services

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
27	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the SFIs
28	FULL	PERFORMANCE & ASSURANCE	Approve the UHB's audit and assurance arrangements
29	FULL	PERFORMANCE & ASSURANCE	Receive reports from the UHB's Executive on progress and performance in the delivery of the UHB's strategic aims, objectives and priorities and approve action required, including improvement plans
30	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Board's Committees, groups and other internal sources on the UHB's performance and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive reports on the UHB's performance produced by external regulators and inspectors (including, e.g. WAO, HIW, etc) that raise issue or concerns impacting on the UHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the UHB's Chief Internal Auditor and approve action required, including improvement plans
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the UHB's external auditor and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the UHB's performance against Health and Care Standards for Wales and approve action required, including improvement plans
35	FULL	REPORTING	Approve the UHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government
36	FULL	REPORTING	Receive, approve and ensure the publication of UHB reports, including its Annual Report and annual financial accounts

SCHEME OF DELEGATION TO DIRECTORS, ASSOCIATE DIRECTORS AND OFFICERS

The Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Director of Finance & Procurement and other officers. The Chief Executive's Job Description, together with his/her Accountable Officer Memorandum sets out his/her specific responsibilities, and the individual job descriptions determined for 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 Cwm Taf University Health Board Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Agreeing and signing the Integrated Medium Term Plan / Long Term Agreements	Chief Executive	Deputy Chief Executive
Authorisation and monitoring of losses and compensations and ex gratia payments.	Chief Executive	Deputy Chief Executive
Arrangements for the management of land, buildings, and other assets belonging to or leased by the UHB / Capital Schemes	Chief Executive	Director of Planning & Performance
Arranging loans.	Director of Finance	Deputy Director of Finance
Achievement of the three financial targets.	Chief Executive	Deputy Chief Executive
Admission to Performers Lists and similar lists	Chief Executive / Medical Director	Director of Primary Care, Community & Mental Health / Deputy Medical Director

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Changes to Medical Lists.	Medical Director	Director of Primary Care, Community & Mental Health
Controls Assurance/Risk Management.	Director of Corporate Services and Governance / Board Secretary	Operational Head of Workplace Heath, Safety & Fire.
Data Protection arrangements	Chief Executive	Medical Director Director of Corporate Services and Governance / Board Secretary
Debt recovery	Director of Finance	Deputy Director of Finance
Delegation of budgets and approval to spend funds.	Chief Executive	Director of Finance
Development and implementation of Procurement Policy.	Director of Finance	Director of Shared Services
GMS Cash Limited Cost Rent Schemes.	Director of Finance	Deputy Director of Finance
Health and Safety Arrangements.	Chief Executive	Director of Corporate Services and Governance / Board Secretary
Insurance Arrangements (with approval from the relevant division within NHS Wales department)	Director of Finance	Deputy Director of Finance

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/Chief Executive	Director of Corporate Services and Governance / Board Secretary Deputy Chief Executive
Single tenders/ issuing tenders and post tender negotiations.	Chief Executive	Director of Finance
Legal Advice.	Nurse Director	Assistant Director of Quality Improvement and Clinical Governance
NHS Complaints (Concerns) Procedure.	Chief Executive	Deputy Chief Executive
Obstetric List.	Medical Director	Deputy Medical Director
Operation of detailed financial matters, including bank accounts, and banking procedures.	Director of Finance	Deputy Director of Finance
Workforce	Director of Workforce and OD	Assistant Director of Workforce (and OD)
Manage central reserves and contingencies.	Director of Finance	Director of Finance
Management of non exchequer funds.	Chief Executive	Deputy Chief Executive
Management and control of stocks other than pharmacy stocks.	Chief Executive	Deputy Chief Executive
Management and control of pharmacy stock.	Chief Executive	Head of Medicines Management

DELEGATED MATTER	RESPONSIBLE OFFICER(S)	DEPUTY
Management and control of computer systems and facilities.	Chief Executive	Board Director
Monitor and achievement of management cost targets.	Chief Executive	Director of Finance
Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.	Director of Nursing Midwifery and Patient Services	Assistant Director of Nursing
Recording of payments under the losses and compensations regulations.	Director of Finance	Deputy Director of Finance
Special Payments	Chief Executive	Deputy Chief Executive
Sealing and signing of documents.	Chair/Chief Executive	Vice Chair/Deputy Chief Executive
Work relating to counter fraud and corruption in accordance with Welsh Government directions	Director of Finance	Deputy Director of Finance

This scheme only relates to matters delegated by the Board to the Chief Executive and his/her Directors, together with certain other specific matters referred to in Standing Financial Instructions.

Each Director is responsible for delegation within his/her department. He/she should produce a scheme of delegation for matters within his/her department, which should also set out how departmental budget and procedures for approval of expenditure are delegated.

Cwm Taf UHB – Additional delegations linked to the SFIs

Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

SCHEME OF DELEGATION – VERSION CONTROL

Version		Date
1	Initial Draft Prepared by Deputy DOF & Heads of Finance	5/8/15
2	Draft Prepared for Audit Committee October 2015	24/9/15
3	Post Consultation – October 2015	
4	Audit Committee/Executive Board approval January 2016	31/12/15
5	Audit Committee April 2016	5/4/16
6	Audit Committee April 2017 – Amendment of Pharmacy Ordering Limits (section 11)	3/4/17
7	**Audit Committee September 2017 – Addition to General Payroll Approvals (section 10)**	**11/9/17**

Introduction

The Standing Orders (SOs) and Standing Financial Instructions (SFIs) specify key responsibilities of the Chief Executive, Director of Finance and other Officers.

The Chief Executive's Job Description, together with her Accountable Officer Memorandum, sets out her specific responsibilities. Individual Job Descriptions determined for Director level posts also define in detail the specific responsibilities assigned to those post holders.

The SOs, together with its schedule of delegations, and the financial delegations set out in the SFIs form the basis of the Health Board's Scheme of Delegation to Officers.

This Schedule of additional delegations identifies those specific areas within the SFIs which require additional delegations from the Chief Executive, the Director of Finance and other Officers.

This Schedule should not be read in isolation and needs to be used alongside the full SFIs available via sharepoint.

A general principle to note is that, for automated processes, a Director may further delegate to a deputy during periods of absence although they will still retain responsibility for the delegation. Manual processes can only be delegated upwards (except for legal claims settlement where the Director of Nursing may delegate to a deputy – see page 37).

Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

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Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

1. General

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.	2.3.2	Director of Finance	All Heads of Finance
B	Ensure that any contractor or employee of a contractor who is empowered by the UHB to commit the UHB to expenditure or who is authorised to obtain income shall be covered by the SFIs	2.5.1	CEO	Assistant or Deputy Directors of Directorate engaging the contractor

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2. Audit, Fraud & Corruption, and Security Management

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function.	3.2.1	CEO	Board Secretary
B	Monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management. Controlling and co-ordinating security.	3.6.1 3.6.2	CEO CEO	Director of Facilities Director of Facilities

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3. Allocations and Financial Duty

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution including any sums to be held in reserve Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and Regularly update the Board on significant changes to the initial allocation and the application of such funds.	4.0.2	Director of Finance	No delegation

4. Budgetary Control

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Prepare and submit budgets for approval and delegation by the Board. Monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every Board meeting. Any significant variances should be reported to UHB members as soon as they come to light and the Board shall be advised on any action to be taken in respect of such variances.	6.1.1 6.1.2	Director of Finance Director of Finance	No Delegation
B	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	6.1.4	Budget holders	Formal sign off required at Directorate level only -See B1 below

		Delegated to:	Signed off by:
B1	Delegation of the management of defined Revenue budgets to budget holders: i. Revenue budgets for Clinical Directorates ii. Revenue budgets for Corporate directorates iii. Reserves	i. Budget Holders ii. Budget Holders iii. Deputy DOF	i. Clinical Directors and Directorate Managers. ii. Corporate Directors and Assistant Directors

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Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	Ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.	6.1.5	Director of Finance	Heads of Finance
D	Delegation of the management of a budget to permit the performance of a defined range of activities (including pooled budgets)	6.2.1	CEO	Revenue budget -Director of Finance (See B1) Capital budget – Director of Planning & Strategy
E	Delegation to include the authority to exercise virement and budget transfers	6.2.1	CEO	See E1 below

E1-Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to revenue *& vice versa*
Within a department	Budget manager plus line manager	Not allowed
Within a directorate; between departments	Directorate Manager	
Between directorates	Directorate Manager of both directorates	
Budget transfers between Reserves and Delegated budgets	Deputy Director of Finance	

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Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
F	Devise and maintain systems of budgetary control.	6.3.1	Director of Finance	Heads of Finance
G	The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans.	6.3.3	CEO	Executive Directors
H	All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks	6.5.2	CEO and Director of Finance	No Delegation

5. Annual Accounts and Reports

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Ensuring that financial reports and returns are prepared in accordance with the accounting policies and guidance determined by the Welsh Ministers and the Treasury and consistent with International Financial Reporting Standards.	7.0.3	Director of Finance	No Delegation
B	The UHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.	7.0.5	Board	Board Secretary/Director of Corporate Services

6. Banking arrangements

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made	9.2.1	Director of Finance	Head of Finance
B	The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include: i. The conditions under which bank accounts is to be operated ii. Those authorized to sign cheques or other orders drawn on the UHB accounts	9.3.1	Director of Finance	i. Head of Finance ii. See B1 below
B1	**Day to day operation of bank accounts:** i. maintain list of approved signatories for manual payments ii. approval to authorize automated payments: •accounts payable[1] •payroll •primary care contractors iii. maintain list of bankline authorizers and users for internet banking transactions			i. Head of Finance ii. NHSWSSP Iii Head of Finance

[1]after confirmation from Head of Finance that sufficient funds are available in the bank account

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7. Income, fees and charges and security of cash, cheques and other negotiable instruments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	**Income Systems**. Designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. Ensuring that systems are in place for the prompt banking of all monies received. (i) General Offices in Hospitals (ii) Other Locations	10.2.1	Director of Finance Director of Finance	Head of Finance (i) Director of Facilities (ii) Heads of Department
B	**Fees and Charges**- Approving and regularly reviewing the level of all fees and charges , other than those determined by the Welsh ministers or by statute	10.3.1	Director of Finance	See below

	Fees and Charges:	Authority Delegated to
B1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	i. Annual value upto £10m -Director of Finance Annual value over £10m- Chief Executive ii. Up to £200,000- Director of Finance Over £200,000 – Chief Executive

B2	**Service Level Agreements – NHS and Non NHS** Agreement to provide services with an annual value: i. up to £50,000 ii. upto £100,000 iii. Over £100,000	i. Directorate manager and Head of Finance ii. Relevant Director and Deputy Director of Finance iii. Relevant Director and Director of Finance
B3	**Individual NHS patient treatment charges outside of LTAs and SLAs** Agreement to provide treatment: i. up to £5,000 ii. over £5,000	i. Head of Contracting ii. Head of Finance
B4	**Private Patients and overseas patients without reciprocal agreements** i. pricing policy and price structure ii. payment policy, including use of deposits, income guarantees, arrangements with insurance companies	i. Director of Finance ii. Director of Finance
B5	**Commercial sponsorship offers (including funding contributions for staff & non staff costs)** Agreement to receive commercial sponsorship or funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100, 000	i. Directorate manager and Head of Finance ii. Relevant Director and Deputy Director of Finance iii. Relevant Director and Director of Finance
B6	**Approval of concession arrangements**	Director of Finance

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B7	**Commercial and non commercial research projects and trials** Agreement to receive funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100, 000	i. Directorate manager and Head of Finance responsible for Research plus Asst Director for R&D ii. Relevant Director and Deputy Director of Finance plus Asst Director for R&D iii. Relevant Director and Director of Finance plus Asst Director for R&D
B8	**Agreements for non patient care fees and charges (e.g. tenancy agreements rents ,licences)** Agreement to enter into agreements based on total annual income: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Directorate manager /Asst Director and Head of Finance ii. Relevant Director and Deputy Director of Finance iii. Relevant Director and Director of Finance

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Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
C	**Debt recovery-** (i) Appropriate recovery action on all outstanding debts. (ii) Ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	10.4.1 10.4.4	Director of Finance Chief Executive & Director of Finance	Head of Finance Deputy Director of Finance
D	**Security of cash, cheques and other negotiable instruments-** Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable, and establishing systems and procedures for handling cash and negotiable securities on behalf of the UHB. The provision of adequate facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;	10.5.1	Director of Finance	Head of Finance Director of Facilities/ Heads of Departments

8. Grant funding, procurement and contracts for goods and services

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Maintaining detailed policies and procedures for all aspects of grant funding- i.e. awarding of grants	11.1	CEO	Director of Planning
B	Maintaining detailed policies and procedures for procurement, tendering and contracting	11.4.2	CEO	Director of Finance
C	All contracts exceeding the delegated limit[1], all acquisitions and disposals of land of any limit, and the acceptance of gifts of property, must receive the written approval of the Welsh Ministers before being entered into. (i) Contracts (ii) Acquisition and disposals of land, and acceptance of gifts of property	11.9.5	Board	(i) Director of Finance (ii) Director of Planning
D	**Procurement Thresholds** Minimum thresholds for quotes and competitive tendering arrangements	11.10	Director of Finance	Section 11C below
E	**Contract Management.** The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the UHB so as to ensure that obligations on delivery of business and operational objectives, and achieving value for money, are met	11.12.1	CEO	Executive Directors

[1]Current delegated limit for contracts before requiring Ministerial approval is £1m

9. Contracts for Health Care Services

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	The CEO is responsible for ensuring the UHB enters into suitable Health Care Agreements or individual patient commissioning agreements where appropriate.	12.1	CEO	See A1 – A12 below
B	The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance and associated financial implications of all Health Care Agreements	12.3	CEO	Head of Finance

	Agreements for the purchase of services	Authority delegated to
A1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	i. Annual value upto £10m -Director of Finance Annual value over £10m- Chief Executive ii. Up to £200,000- Director of Finance Over £200,000 – Chief Executive
A2	**Service Level Agreements - NHS** Agreement to purchase services with an annual value: i. up to £50,000 ii. upto £100,000 iii. Over £100,000	i. Directorate manager and Head of Finance ii. Relevant Director and Deputy Director of Finance iii. Relevant Director and Director of Finance

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A3	**Grant funding agreements** Agreement to give a grant with a total value: i. up to £5,000 ii. £5,000 to £25,000 iii. Over £25,000	i. Directorate manager and Head of Finance ii. Relevant Director and Deputy Director of Finance iii. Relevant Director and Director of Finance
A4	**Individual Continuing Healthcare Placements /Packages** Authorisation of individual placements/packages following recommendation from the CHC Panel : i. Annual value up to £30,000 ii. Annual value between £30,000 and £60,000 iii. Annual value over £60,000 iv. Agreement of changes to annual standard rates	i. Chair of CHC Panel ii. Director of Nursing & Director of Finance iii. Chief Executive iv. Director of Nursing & Director of Finance
A5	**NHS Funded Nursing Care (FNC)** i. Authorisation of individual placements/packages following recommendation from a Nurse Assessor ii. Agreement of changes to annual standard rates	i. FNC Co-ordinator ii. Director of Nursing & Director of Finance
A6	**Individual Patient Commissioning Agreements – NHS Providers and non NHS providers (including European Economic Area applications)** Authorisation of individual agreements following recommendation from the IPC Panel: i. Annual value up to £50,000 ii. Annual value over £50,000	i. Director of Public Health ii. Chief Executive or Director of Finance

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A7	**Primary Care Contracts – General Medical Services (excluding enhanced services)** i. Approval and Signing of the GMS contracts with practices ii. Variations to the Agreement iii. Payments under the contracts	i. Director of Primary care ii. Director of Primary care iii. Delegated to NHSWSSP
A8	**Primary Care Contracts – General Medical Services (Enhanced services)** i. Approval and Signing of agreements to provide Enhanced services ii. Variations to the Agreement iii. Payments under the Agreements	i. Director of Primary care ii. Director of Primary care iii. Delegated to NHSWSSP
A9	**Primary Care Contracts – General Dental Services** i. Approval and Signing of the GDS contracts with practices ii. Amendments to the Agreement iii. Payments under the contracts	i. Director of Primary care ii. Director of Primary care iii. Delegated to NHSWSSP
A10	**Primary Care Contracts – Pharmaceutical Services (including enhanced and advanced services)** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NHSWWP ii. Director with responsibility for Medicines Management
A11	**Primary Care Contracts – General Ophthalmic Services** i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NHSWWP ii. Director of Primary care
A12	**Providing services jointly with Local authorities under Section 32 and 33 of NHS (Wales) Act 2006.** i. Approval and Signing of the pooled budget arrangements ii. Amendments to the Agreement	i. Relevant Director and Director of Finance ii. Relevant Director and Director of Finance

10. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.	13.2.2	CEO	Director of Finance
B	No Board member or UHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	13.3.1	CEO	Director of Finance

	New Appointments, Bank and agency costs	Delegated Approval / Sign Off by:
B1	Employment of all fixed term and permanent staff – except medical consultants	VR form signed by Directorate manager and Finance lead prior to submission to VCP
B2	Employment of fixed term and permanent staff (subject to any vacancy review policy in place)- Medical consultants only	VR form signed by Directorate manager and Finance lead prior to submission to Executive Catch up Meeting
B3	Nursing bank and On contract agency	Ward Manager

B4	Nursing agency Off contract	Directorate Manager
B5	Medical agency - On Contract - Off Contract	Directorate Manager Executive Director
B6	Engage non-medical, non-payroll staff (subject to contracting and tax assurance rules):*	**Director of W&OD and Head of Procurement to confirm agreement on off contract hires prior to any commitment.**
	- Below **£10k** gross commitment	Directorate Manager
	- **£10k** to **£25k** gross commitment	Deputy/Assistant Director
	- **up to £50k gross commitment**	Executive Directors
	- **> £50k gross commitment**	Chief Executive

[1]Urgent Out of Hours request to be approved by the Executive Director on call

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	Procedures to be presented by the Chief Executive for Board approval for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies	13.3.2	CEO	Director of Workforce & OD
D	The Director of Workforce and Organisational Development is responsible for securing the provision of an efficient, value for money payroll service.	13.4.1	Director of Workforce & OD	No delegation

E	(i) Ensuring that any shared or hosted service arrangement is supported by appropriate contract terms and conditions, adequate internal controls and audit review procedures; (ii) Ensuring a sound system of internal control and audit review of any internally provided payroll service; (iii) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.	13.4.2	CEO	(i) Director of Workforce & OD (ii) Director of Finance (iii) Head of Finance
F	Appropriately nominated managers have delegated responsibility for: (i) Submitting time records, and other notifications in accordance with agreed timetables; (ii) Completing time records and other notifications in accordance with the contract of Service Level Agreements; (iii) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement	13.4.3	CEO	See below

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	General Payroll Approvals	Delegated to
F1	Grant additional increments to staff (outside of Department of Health national T&C)	Director of Workforce and OD Noted at Remuneration Committee
F2	Electronic and paper timesheets and other reporting forms to confirm: • Non-attendance at work; • sickness and absence records; • overtime, unsocial hours and on call.	Line Managers (as determined by Directorate Manager or equivalent)
F3	Travel and subsistence claims (via e-expenses)	Line Manager
F4	Annual leave applications	Line Manager
F5	Applications for carry forward of annual leave to next year within A4C limits/Medical & Dental Handbook	Directorate Manager (or equivalent)
F6	Annual leave carry forward to next year in excess of A4C limits	Executive Director
F7	Buying additional annual leave	Directorate Manager (or equivalent)
F8	Study leave applications	Line Manager
F9	Salary Sacrifice Scheme applications	Assistant Director of Workforce and OD
F10	Specific benefits in kind i. Lease cars ii. Authorised phone user, remote access and good apps	Directorate Manager (or equivalent)
F11	Termination Forms	Directorate Manager (or equivalent)
F12	Staff Change Forms impacting on pay (e.g. change of hours, re-grading, extension of fixed term contracts etc)	Directorate Manager (or equivalent)

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Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
G	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment (i) Non-medical posts advertised on NHS Jobs (ii) Non-medical posts not advertised via NHS Jobs (iii) Medical posts (wherever advertised)	13.5.1	Director of Workforce & OD	 (i) NWSSP (ii) & (iii) no delegation

G1	**Approve departure under compromise agreement** (VERs) • Up to £50k • Above £50k	i. All applications to be approved by Directorate manager/Head of Finance plus Executive Director. ii. All applications also need to be approved by the Remuneration Committee iii. Any VER payments over £50k also need to be approved by WG.
G2	**Approve redundancy**	i. Remuneration Committee (subject to any Welsh Government approval mechanisms)
G3	**Approve departure under compromise agreement** (other than VERs)	Relevant Executive Director and Director of W&OD* (subject to any Welsh Government approval mechanisms)

*Any agreements that are deemed contentious to be referred to Remuneration Committee

11. Non Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The CEO will approve the level of non pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the UHB's scheme of delegation	14.1	CEO	See Below for Oracle and non Oracle requisitions[1]

[1] All Financial Limits shown below are **exclusive** of VAT

ORACLE REQUISITIONS	Authority Delegated to
Below **£1,500**	Tier 6 – Nominated Budget holder for specific cost centres
£1,500 to **£5,000**	Tier 5 Head of Department or equivalent
Up to £25,000	Tier 4 - Directorate Manager or equivalent
Up to £50,000	Tier 3 – Assistant/Deputy Director
Up to £100,000	Tier 2 -Executive Director
Upto £500,000	Tier 1 – Director of Finance
Over £500,000	Chief Executive

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Expenditure commitments made outside of the ORACLE requisition process		Authority Delegated to
Contracts for HealthCare Services	See Section 5	See Section 5
Pharmacy drugs ordered via Pharmacy system	i. Up to £75,000 ii. Up to £50,000 iii. Up to £20,000	i. Head of Medicines Management ii. Chief Pharmacists iii. Pharmacy Team Leaders
Pension Agency Invoices (Injury Benefit/Compensation)	i. > £100,000 ii. < £100,000	iii. Director of Finance iv. Deputy Director of Finance
Legal Claims and Defence costs	i. >£50,000 ii. <£50,000 iii. <£20,000 iv. <£5,000 v. <£1,500	i. Chief Executive ii. Director of nursing & quality iii. Assistant Director Quality Improvement & Clinical Governance iv. Assistant Director of nursing and quality v. Head of Quality

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Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
B	Maintaining the list of managers who are authorized to place requisitions for the supply of goods and services for both Oracle and Non Oracle requisitions.	14.1.2 & 14.1.3	CEO	Head of Finance
C	The Director of Finance will advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders should be sought.	14.3.1	Director of Finance	See Below

Value[1]	Minimum Competition[2]	Lead	Waivers, or exceptions to tender rules
Up to **£5,000**	Best value to be shown	Tier 5	-
£5,000 to **£24,999**	**3 quotations**	Procurement Services	Head of Procurement or Director of Finance or CEO
£25,000 to OJEU threshold for supplies and services[3] **£25,000** to **£1m** for works	**4 tenders**	Procurement Services	Single Tender Action Authorised by CEO
Above OJEU threshold for supplies and services[3] to **£1m**	**5 tenders**	Procurement Services	Single tender action prohibited
Above OJEU threshold for works[4]	**Procured via Designed for Life: Building for Wales**	Procurement Services	Single tender action prohibited
Over **£1m (other than D4L)**	**WG approval required**	Procurement Services	-

[1] Total value excluding VAT.

[2] Subject to existence of suitable suppliers

[3] Threshold from January 2014 for Supply and Services is £111,676

[4] Threshold from January 2014 for works is £4,322,012

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	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
D	**Petty cash** • Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance • Petty cash records are maintained in a form as determined by the Director of Finance	14.6.1	Director of Finance Director of Finance	Head of Finance Head of Finance
E	**Approve petty cash expenditure** i. up to £50 per transaction ii. over £50 per transaction			i. Budget Manager ii. Executive Director
F	• The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh ministers. • The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the UHB's scheme of delegation	14.6.2	Chief Executive and Director of Finance	Director of Planning

12. Capital investment, fixed asset registers and security of assets

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	(i) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans (ii) management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost (iii) ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received; (iv) ensure that an annual capital programme is adopted by the Board prior to the commencement of the financial year (v) ensure the availability of resources to finance all revenue consequences of the investment, including capital charges (vi) ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported	15.1.1	CEO	(i) to (iv) Director of Planning (v) Director of Finance (vi) Head of Capital Planning
B	The CEO will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the UHB's SOs.	15.1.7	CEO	See below

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Capital Schemes funded by Discretionary Allocation

Discretionary Capital Programme Approvals	Gross Expenditure on Whole Project			
Approval / Sign Off[2] by:	**Initial Annual Discretionary Programme**	**New Approvals Schemes under £500k**	**Scheme over £500K to £1m**	**Schemes over £1m[1]**
Executive Board			Agree project mandate and priority	
Directorate Manager	Sign Statement of Need (SON)	Sign Statement of Need (SON)	Sign Statement of Need (SON) and BJC if requested by ECMG	Sign BJC
Executive Director	-	-	Sign BJC	Sign BJC
Director of Finance	-	-	Review and agreement	Review and agreement
Executive Capital Management Group (ECMG)	Recommend	**Approve**	**Approve BJC or refer to CPB for approval**	Recommend
Capital Programme Board (CPB)	**Approve**	Noted	Approval if required	**Approve**
Health Board	Ratified	Noted quarterly	Noted quarterly	**Approve**

[1] Projects over £1m need to get approval from the WG
[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the proposal

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Capital Schemes funded by Welsh Government

Scheme under £4m	Scheme over £4m
Executive Team considers overall priorities and project mandates	
↓	↓
Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off	Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off
↓	↓
Business Justification Template signed of by Directorate manager and Executive Director	Strategic Outline Case signed of f by Capital Programme Board and Health Board
↓	↓
ECMG Discussion and recommendation	Outline Business Case signed of f by Capital Programme Board and Health Board
↓	↓
Discussion and approval at Capital Programme Board if over £1m.	Full Business Case signed of f by Capital Programme Board and Health Board
	↓
Submission to WG for approval	Final approval required from WG at each stage of Business Case process

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	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
C	The Director of Finance shall issue procedures governing the financial management, including variations to contract of capital investment projects and valuation for accounting purposes	15.1.8	Director of Finance	See Below

Capital orders and payment authorisation

Delegated authority	Variations to Discretionary Schemes	Variations to Capital Schemes funded by WG (within Approved Sum)	Financial monitoring and reporting responsibility	Enter lease arrangement (all types) total value
Up to **£5k**	Assistant Director of Planning (and reported to ECMG)	External Project Manager (following agreement with the Head of Capital Planning	Head of Capital Planning and Head of Finance	Director of Finance
Up to **£20k**	Director of Planning (and reported at ECMG)	Head of Capital Planning		Director of Finance
Up to **£50k**	ECMG	Assistant Director of Planning		
Up to **£100k**	ECMG	Director of Planning		CEO **and** Director of Finance **and relevant** Director
Over **£100k**	Capital Programme Board All changes over £100k also need to be reported to ECMG	Director of Planning and CEO/ Deputy CEO All changes over £100k also need to be reported to ECMG and Capital Programme Board		

Any variations to Capital Schemes funded by WG that exceed the approved sum require further approval from WG
If further approval and funding is not provided by WG, the variations needs to be discussed at ECMG and Capital Programme Board

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	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
D	the maintenance of registers of assets, taking account of the advice of the director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically	15.3.1	CEO	Head of Finance

13. Stores and receipt of goods

	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	(i) overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. (ii) The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager (iii) the control of any fuel oil and coal of a designated estates manager.	16.2.1	CEO	Directorate Managers[1] Head of Medicines Management Head of Estates

[1] *Directorate Managers may delegate the day-to-day responsibility to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance*

B	Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year	16.2.4	Director of Finance	Head of Finance
	Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance	16.2.5	Director of Finance	Head of Finance

14. Disposals and condemnations, losses and special payments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	**Disposals and condemnations** a. Prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers. b. All unserviceable articles shall be condemned or otherwise disposed of by an officer authorized for that purpose by the Director of Finance.	17.1	Director of Finance	a. Head of Finance b. Following advice from appropriate heads of service (eg Clinical engineering, IM&T, Estates etc): Estimated value: • up to £1,000 Directorate manager /Corporate manager • £1,000 to £10,000 Deputy Director of Finance • over £10,000 Director of Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
B	**Losses and Special payments** • Ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Assembly Government's Manual for Accounts.	17.2.2	Director of Finance	Head of Finance
	• Ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralized Losses and Special Payments Register and that 'case write off' action is recorded on the system.	17.2.8	Director of Finance	Head of Finance
	• The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs.	17.2.9	Audit committee	See B1 Below
	• Ensure that all losses and special payments are reported to the Audit Committee at every meeting	17.2.13	Director of Finance	Head of Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

B1	**Approve losses, write-offs and compensation payments due to:** i. losses of cash (theft, fraud, etc) ii. damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (theft, fraud, arson) iii. extra contractual payments to contractors; iv. ex-gratia payments to patients and staff for loss of personal effects v. fruitless payments including abandoned capital schemes vi. ex-gratia payments - voluntary release payments to staff vii. bad debts and claims abandoned • No delegated approval over £50,000 – WG approval required	i to iv - Chief Executive/ Deputy Chief Executive (within delegated limits issued by Welsh Government - £50,000) v. Chief Executive/ Deputy Chief Executive (delegated limits £250,000) vi. Remuneration Committee (within delegated limits issued by Welsh Government - £50,000) vii. Head of Finance (<£1,000), Deputy Director of Finance (£1,000 to £10,000) Director of Finance (£10,000 to £25,000) CEO (£25,000 to £50,000).

Cwm Taf UHB – Additional delegations linked to the SFIs

Version 7

B2	**Approve compensation payments made under legal obligation** • Personal injury and medical negligence claims i. up to £1,500 ii. £1,500 to £5,000 iii. £5,000 to £20,000 iv. £20,000 to £50,000 v. £50,000 to £1m • Employment matters i. up to £20,000 ii. £20,000 to £50,000 iii over £50,000 • Other matters	• Personal injury and medical negligence claims- On receipt of legal advice to pay i. Head of Quality ii. Assistant Director of Nursing and Quality iii. Assistant Director Quality Improvement & Clinical Governance iv. Director of Nursing* v. Chief Executive • Employment claims – on receipt of legal advice/tribunal i. Deputy Director of Workforce & OD ii Director of Workforce & OD iii Chief Executive • Chief Executive
B3	**Approve compensation payments made without legal obligation**	Chief Executive / Deputy Chief Executive (within delegated limits issued by Welsh Government - £50,000)

*Director of Nursing may delegate this authority to a Deputy during periods of absence.

Cwm Taf UHB – Additional delegations linked to the SFIs

15. Information Management & Technology

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The UHB shall publish and maintain a Freedom of Information (FOI) publication scheme, or adopt a model publication scheme approved by the Information Commissioner.	18.1.2	Board	Board Secretary/Director of Corporate Services and Governance
B	The responsible Director for IM&T has responsibility for: • the accuracy and security of the computerised data of the UHB • ensuring that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. • Where another health organisation or any other agency provides a computer service for financial applications, the responsible Director for IM&T shall periodically seek assurances that adequate controls are in operation. • ensuring that the risks to the UHB arising from the use of IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of an appropriate disaster recovery plan.	18.2.1 18.4.1 18.4.2 18.5.1	Director of IM&T	No Delegation other than responsibilities for security of patient data is delegated to the Medical Director in the role of Caldicott Guardian

Cwm Taf UHB – Additional delegations linked to the SFIs

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
C	The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.	18.3.1	Director of Finance	Head of Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

16. Patients' property

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	Ensuring patients or their guardians have appropriate information before or at admission, including that the UHB will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt	19.2.1	CEO	Heads of Nursing/ Heads of Service
B	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	19.3.1	Director of Finance	Head of Finance

Cwm Taf UHB – Additional delegations linked to the SFIs

17. Funds held on Trust

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Schedule of Matters reserved to the Board and the Scheme of delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom	20.2.2	Board	See below

Access to Charitable funds

Delegated authority	Approve expenditure from charitable funds
(i) Approval and setting up of designated fund signatories for new funds. (ii) Approval of changes to fund signatories	(i) Chief Executive/Deputy Chief Executive (ii) Head of Finance
All expenditure requests for Charitable funds	To be submitted to Senior Finance Officer - Charitable Funds for initial review
Up to **£5,000 (non-contentious)**[1]	Designated fund signatories subject to confirmation from the Senior Finance Officer that sufficient funds are available
Over **£5,000 (+** under £5,000 if deemed contentious)	CEO or Deputy CEO

[1]The term "contentious" refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives and will be determined by the Senior Finance Officer - Charitable Funds during initial review.

Cwm Taf UHB – Additional delegations linked to the SFIs

Investment of Charitable Funds

Investments	Authority
Investment of funds	
i. Decision on nature and value of investment[1]	i. Audit committee with guidance from appointed investment advisors and Director of Finance
ii. Placing of investment	ii. Chief Executive and Director of Finance via an authorization to pay into the advisors' investment account

[1]The term "investment" refers to stocks, shares, bonds, property, unit funds or other instruments derived to generate a rate of return and/or valuation gains, other than interest bearing bank accounts

Cwm Taf UHB – Additional delegations linked to the SFIs

18. Retention of Records

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	CEO shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers guidance.	21.1.1	CEO	Relevant Executive Director

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

LHB Framework

The University Health Board's governance and accountability framework comprises these Standing Orders (SOs), incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***Standing Financial Instructions (SFIs)***
- ***Values and Standards of Behaviour Framework***
- ***Board Assurance Framework***
- ***Key policy documents***

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

These documents may be accessed by contacting the Director of Corporate Services and Governance/ Board Secretary.

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at The Good Governance Guide for NHS Wales Boards. Directions or guidance on specific aspects of LHB business are also issued in hard copy, usually under cover of a Ministerial Letter.

SCHEDULE 3

BOARD COMMITTEE ARRANGEMENTS

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

Terms of Reference and Operating Arrangements for each Committee as follows: -

- Academic Partnership Board (APB)
- Audit Committee
- Charitable Funds Committee
- Quality, Safety & Risk (QSR) Committee
- Finance, Performance & Workforce (FPW) Committee
- Integrated Governance Committee (IGC)
- Mental Health Act Monitoring (MHAM) Committee
- Primary & Community Care (PCC) Committee
- Remuneration and Terms of Service (RATS) Committee

Advisory Groups (refer to Schedule 5)

- Healthcare Professionals Forum (HPF)
- Stakeholder Reference Group (SRG)
- Working in Partnership Forum (Local Partnership Forum)

Terms of Reference and Operating Arrangements for

- The Executive Board (EB)

Sub – Committee	Date Terms of Reference Reviewed	Comment (as at 25 March 2019)
Audit	Approved by Board 26 July 2018	
Integrated Governance	Approved by Board on 31 January 2018	To be reviewed at the next meeting in 2019.
Remuneration & Terms of Service	Approved by the Board November 2016	To be reviewed at the next meeting in 2019.
Quality, Safety & Risk	Approved by Board 31 May 2018	

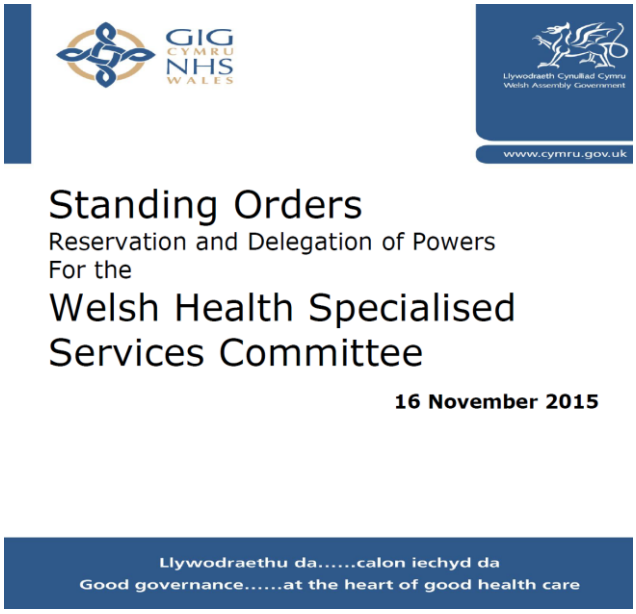
Sub – Committee	Date Terms of Reference Reviewed	Comment (as at 25 March 2019)
Primary & Community Care	Approved by Board 26 July 2018	
Finance, Performance & Workforce	Approved by Board 26 July 2018	
Academic Partnership Board	Approved by Board 18 Jan 2017	
Mental Health Act Monitoring	Approved by the Committee in Aug 2018	To be ratified by the Board
Executive Board	Approved by the Executive Board 24 October 2018	

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

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

Welsh Health Specialised Services Committee (WHSSC)



The WHSSC Standing Orders can be accessed on the link below:

http://www.whssc.wales.nhs.uk/sitesplus/documents/1119/G%26A%20Framework%20full.pdf

Emergency Ambulance Services Committee (EASC)

The link to the EASC Standing Orders (developed following the decoupling from WHSSC) can be accessed on the link below:
http://www.wales.nhs.uk/easc/home

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

Advisory Group	Date Terms of Reference Reviewed	Attachment	Comment (as at April 2019)
Health Professionals Forum (HPF)	Approved by Board 3 May 2017	HPF Terms of Reference UHB 3 May	The Health Professionals Forum has not met since July 2018 Next meeting planned to take place in Spring 2019 with staff from Bridgend
Stakeholder Reference Group (SRG)	Approved by Board 31 January 2018	SRG TOR 2017 - Draft UHB 31 Jan 201	
Working in Partnership Forum (WIPF)		See section 4.23 of the Standing Orders	There is an ongoing review of the WIPF including changing the frequency of meetings.

Schedule 6

GLOSSARY OF TERMS

This Glossary of Terms should be used in conjunction with the Local Health Board's Standing Orders and Standing Financial Instructions; and also with the Welsh Health Specialised Services; Emergency Ambulance Services Committees Standing Orders and Standing Financial Instructions

Term	Explanation
Accountable Officer	The officer formally designated as the LHB's 'Accountable Officer' by the Chief Executive, NHS Wales. In LHBs, the Chief Executive must be the designated Accountable Officer, and this is a condition of their appointment to the role. The essence of the role of Accountable Officer is the designation of personal responsibility for the propriety and regularity of the public finances for which the AO is answerable.
Accounting Officer	The person holding the post of Director General, Department for Health and Social Services and Chief Executive, NHS Wales who has been formally designated the Assembly Government's Accounting Officer for Health and Social Services.
Advisory Group	A Group, created and appointed by the LHB Board to provide advice in the exercise of its functions. The LHB's advisory groups include a Stakeholder Reference Group, Healthcare Professionals' Forum, and Local Partnership Forum.
Annual Plan of Board Business	Annual Plan of Board Business will include proposals on meeting dates, venues and coverage of business activity during the year
Assembly Government	The Welsh Ministers or any person whose authority emanates from the Welsh Ministers.
Associate Member	*For LHB:* A board member who has been appointed to bring a particular perspective to the Board and to participate in Board debate and discussions, but who does not have voting rights.

Term	Explanation
	For WHSSC: The Chief Executives of Velindre NHS Trust, the Welsh Ambulance Services NHS Trust and the Public Health Wales NHS Trust who has been appointed to bring a particular perspective to the Joint Committee and to participate in Joint Committee debate and discussions but do not have voting rights. For EASC: Three associate members who will be the Chief Executives of Velindre NHS Trust, the Welsh Ambulance Services NHS Trust and Public Wales NHS Trust. Associate members may not vote in any meetings or proceedings of the Joint Committee
Audit Committee	*For WHSSC and EASC:* The Joint Committees Audit Committee.
Board	The corporate, decision making body of the LHB. Its role is to set its strategic direction; establish and uphold its governance and accountability framework, including its values and standards of behaviour; and to ensure delivery of its aims and objectives through effective challenge and scrutiny of performance across all areas of activity.
Board members	All members of the Board, including the Chair, Vice Chair, officer members (known as Executive Directors), non officer members (collectively with the Chair and Vice Chair known as Independent Members) and Associate (non voting) members.
Board Secretary	The person appointed by the Board as its principal advisor on all aspects of governance.
CASC	Chief Ambulance Services Commissioner employed by the host Local Health Board to lead the Welsh health ambulance services team
Chair	*For LHB:* The LHB Chair or Chair of the Board (or LHB), means the person appointed by the Minister to lead the Board and to ensure it successfully discharges its overall responsibility for the LHB as a whole. *For WHSSC:* The WHSSC or Joint Committee Chair or Chair of the WHSSC (or Joint Committee), means the person appointed by the Minister to lead the Joint Committee and to ensure it successfully discharges its overall responsibility for the Joint Committee as a whole.

Term	Explanation
	For EASC: The EASC or Joint Committee Chair or Chair of the EASC (or Joint Committee), means the person appointed by the Minister to lead the Joint Committee and to ensure it successfully discharges its overall responsibility for the Joint Committee as a whole.
Chief Executive	*For LHB:* The Chief Officer of the LHB. *For WHSSC:* The Chief Executive of the host LHB. For EASC: The Chief Executive of the host LHB.
Chief Executive, NHS Wales	The person holding the post of Director General Health and Social Services, Welsh Government, and Chief Executive, NHS Wales .
Committee	A Committee or sub-Committee, created and appointed by the LHB or, in the case of a joint-Committee or joint sub-Committee created and appointed by the LHB or by another organisation and approved by the LHB.
Committee Members	*For LHB:* Those persons formally appointed by the Board to sit on or to chair specific Committees. *For WHSSC:* The LHB Chief Executives together with the Joint Committee Chair appointed by the Minister and two Independent Members appointed by the Joint Committee from existing Independent Members of a LHB (and one of whom will be the Vice-Chair) and Associate (non voting) members. For EASC: The LHB Chief Executives together with the Committee Chair appointed by the Minister and two Independent Members appointed by the Joint Committee from existing Independent Members of a LHB (and one of whom will be the Vice-Chair) and Associate (non voting) members.
Committee Secretary	*For WHSSC:* The person appointed by the Joint Committee as its principal advisor on all aspects of governance. For EASC: The Board Secretary (of the host organisation) as its principal advisor on all aspects of governance.
Constitution Regulations	The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (2009/779 (W.67))
Director General, Health and Social Services	The person holding the post of the Welsh Government's Director General, responsible for the Health and Social Services Directorate General and Chief Executive, NHS Wales.

Term	Explanation
Director of Finance	*For LHB:* The chief financial officer of the LHB. *For WHSSC:* The Finance Director of Specialised and Tertiary Services. For EASC: The chief financial officer of the host LHB.
Emergency Ambulance Services Committee EASC Directions	2014 No. 8 (W.8) Sections 11, 12(3), 13(2) (c) and (4) (c) and 203(9) and (10) of and paragraph 4 of Schedule 2 to the National Health Service (Wales) Act 2006(1). The Emergency Ambulance Services Committee (Wales) Directions 2014 The Emergency Ambulance Services Committee (Wales) Amendment Directions 2016
Emergency Ambulance Services Committee EASC Regulations	2014 No 566 (W.67) The National Health Service, Wales The Emergency Ambulance Services Committee (Wales) Regulations 2014
Emergency Ambulance Services Committee EASC	The Committee is made up of the Chief Executives of the Health Boards, Chief Ambulance Services Commissioner and Independent Chair, appointed by the Minister for Health and Social Care via the public appointments process. An officer member employed by the host LHB will also form part of the membership of the Committee. In addition, there will be three associate members who will be the Chief Executives of Velindre NHS Trust, the Welsh Ambulance Services NHS Trust and Public Wales NHS Trust. Associate members may not vote in any meetings or proceedings of the Joint Committee
Executive Director(s)	Officer member(s) of the Board. There are nine Executive Directors (including the Chief Officer) with responsibility for the following areas: Medical; Finance; Nursing; Primary Care, Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science.
Functions	*For LHB:* Those functions defined in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 (2009/1511 (W.147)) and in other legislation.

Term	Explanation
	For WHSSC: Those functions listed in Annex 1 of the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) and subject to any variations to those functions agreed from time to time by the Joint Committee. For EASC: Those functions listed in the EASC (Wales) Directions 2014 No.8 (W.8) and the Emergency Ambulance Services Committee (Wales) Amendment Directions 2016 - the planning and securing of emergency ambulance services for the sick and injured and to be responsible for commissioning Non-Emergency Patient Transport (NEPT) services via the Emergency Ambulance Services Committee from April 2016.
Funds held on trust	Those funds which the LHB holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 163 of the National Health Service (Wales) Act 2006 (C.42). Such funds may or may not be charitable.
Host LHB	*For WHSSC:* Cwm Taf University Health Board *For EASC*: Cwm Taf University Health Board
Independent Member(s)	Collectively the Chair, Vice-Chair and the Non Officer Member(s) of the Board.
Integrated Medium Term Plans	Plans prepared, submitted and approved in accordance with the NHS Finance (Wales) Act 2014 and as defined by the NHS Wales Planning Framework
HEIW	Health, Education and Improvement Wales
Joint Committees	For WHSSC: The Welsh Health Specialised Services Committee established pursuant to the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). For EASC: The Emergency Ambulance Services Committee established pursuant to the Emergency Ambulance Services Committee (Wales) Amendment Directions 2016 No 8 (W.8)
Joint Committees Audit Committee	*For WHSSC:* The Welsh Health Specialised Services Committee's Audit Committee. *For EASC:* The Emergency Ambulance Services Committee's Audit Committee.
Lead Director	*For WHSSC:* The Director of Specialised and Tertiary Services. *For EASC:* The Chief Ambulance Services Commissioner

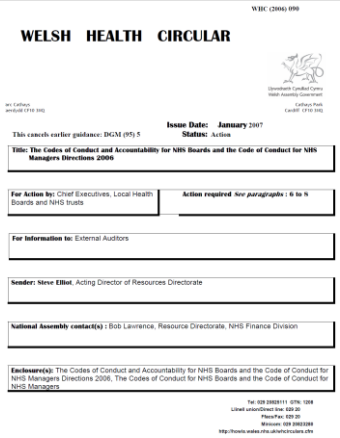
Term	Explanation
UHB	University Health Board.
LHBs	Local Health Boards
Management Team	*For WHSSC:* Consists of the Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, the Medical Director of Specialised and Tertiary Services and the Nurse Director of Specialised and Tertiary Services. For EASC: Consists for the Chief Ambulance Services Commissioner, the Deputy Chief Ambulance Services Commissioner
Ministers or Minister	Either, collectively Welsh Ministers, or separately the Minister for Health and Social Care for Wales.
National Imaging Academy (NIA)	Hosted by Cwm Taf; set up by the NHS Wales Collaborative with funding from the Welsh Government
National Assembly	The National Assembly for Wales, or any person whose authority emanates from the National Assembly for Wales.
NHS	The National Health Service.
NHS Act 2006	The National Health Service Act 2006 (C.41).
NHS (Wales) Act 2006	The National Health Service (Wales) Act 2006 (C.42).
NHS Finance (Wales) Act 2014	The National Health Service Finance (Wales) Act 2014
NWSSP	The NHS Wales Shared Services Partnership
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within these Standing Orders and related Standing Financial Instructions.
Non Officer Members (NOMs)	There are nine non-officer members, who must include: a local authority member; a voluntary organisation (or third sector) member; a trade union member; and a person who holds a post in a university that is related to health.
Officer	*For LHB:* An employee of the LHB. In certain circumstances, the term officer may include a person who is employed by another LHB or by a third party contracted to the LHB who carries out functions on behalf of the LHB. *For WHSSC:* An employee of the host LHB who provides administrative support for the running of the Joint Committee.

Term	Explanation
	For EASC: An employee of the host LHB who provides administrative support for the running of the Joint Committee
Officer Members	See Executive Director(s).
Relevant Services	*For WHSSC:* The planning and securing of specialised and tertiary services consisting of those functions and services listed in Annex 1 of the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) and subject to any variations to those functions agreed from time to time by the Joint Committee. *For EASC:* The planning and securing of emergency ambulance services and the planning provision of non emergency patient transport. Subject to any variations to those functions agreed from time to time by the Joint Committee.
SFIs	Standing Financial Instructions.
SOs	Standing Orders.
Values and Standards of Behaviour Framework	The Values and Standards of Behaviour Framework, incorporating NHS Codes of Conduct.
Vice-Chair	The non officer member appointed by the Minister who shall have particular responsibility for primary care, community and mental health services; and to take on the Chair's duties if the Chair is absent for any reason.
WHSSC	The Welsh Health Specialised Services Committee ("the Joint Committee").
WHSSC Directions	The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35).
WHSSC Regulations	The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (2009/3097 (W.270)).
WHSSC SFIs	*For WHSSC:* The Welsh Health Specialised Services Committee Standing Financial Instructions.
WHSSC SOs	*For WHSSC:* The Welsh Health Specialised Services Committee Standing Orders.
WHSST	*For WHSSC:* The Welsh Health Specialised Services Team established to run the day to day business of the Joint Committee.

Term	Explanation
WHSST Directors	*For WHSSC:* Those persons appointed by the Joint Committee, employed by the host LHB, and consist of the Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, the Medical Director of Specialised and Tertiary Services and the Nurse Director of Specialised and Tertiary Services. Collectively, the WHSST Directors make up the Joint Committee's Management Team.

Schedule 7

CODE OF CONDUCT AND ACCOUNTABILITY FOR NHS BOARDS



WHC (2006) 090

WELSH HEALTH CIRCULAR

Issue Date: January 2007
This cancels earlier guidance: DGM (95) 5 Status: Action

Title: The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006

For Action by: Chief Executives, Local Health Boards and NHS trusts

Action required See paragraphs : 6 to 9

For Information to: External Auditors

Sender: Steve Elliot, Acting Director of Resources Directorate

National Assembly contact(s) : Bob Lawrence, Resource Directorate, NHS Finance Division

Enclosure(s): The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006, The Codes of Conduct for NHS Boards and the Code of Conduct for NHS Managers

Code of Conduct & Accountability for NHS Boards

http://www.wales.nhs.uk/documents/WHC%282006%29090.pdf

The Good Governance Guide for NHS Wales Boards (Second Edition)



The Good Governance Guide for NHS Wales Boards

This comprehensive guide is designed to support existing and aspiring Board members of health organisations in their role as leaders of NHS Wales organisations, to ensure the delivery of high quality services, successful outcomes for citizens with services that are accessible and responsive to local need and represent good value for money. The guide outlines the context for Board members of public organisations in Wales and also provides more specific detail on the governance, legislation and policy requirements, emerging good practice and lessons learned in the health service in Wales and elsewhere. To coincide with this guide the Welsh Government has also produced a pocket guide to good governance that provides an overview of the detail, references and material.

Schedule 8

COMMITTEE CHAIRS, CHAMPIONS & MEMBERSHIP

Name	AUDIT	APB	CHARITY	FPW	IGC	MHAM	PCC	REM	QSR	CHAMPION
Marcus Longley (Chair)			√		√			√ Chair		
Maria Thomas (Vice Chair)	√		√		√		√ Chair	√	√ Chair	Mental Health Adult Safeguarding
Keiron Montague (Community)			√	√			√	√	√	Cleanliness Corporate Health Standard
Mel Jehu (Community)			√	√ Chair	√	√ Chair	√	√		Armed Forces / Veterans Health
Vacancy (IT, Governance & Estates)		√	√					√		Freedom of Information Information Governance Whistleblowing
James Hehir (Legal)			√			√		√	√	Welsh Language Equality and Diversity Safeguarding Children Violence & Aggression NHS Concerns & Claims
Paul Griffiths (Finance)	√ Chair		√	√	√			√		Capital & Estates Design
Jayne Sadgrove (University)	√	√	√					√		
Dilys Jouvenat (Third Sector)			√	√			√	√	√	
Robert Smith (Local Authority)			√	√			√	√	√	Organ Donation Committee chair
Nicola Milligan (Trade Union)			√					√	√*	* attends as staff side rep.

Key to Committees

Abbreviation	Full Name of Committee
AUDIT	Audit Committee
APB	Academic Partnership Board
CHARITY	Charitable Funds Committee
FPW	Finance, Performance & Workforce Committee
IGC	Integrated Governance Committee
MHAM	Mental Health Act Monitoring Committee
PCC	Primary and Community Care Committee
REM	Remuneration and Terms of Service Committee
QSR	Quality, Safety & Risk Committee

Equality Impact Assessment (EIA)

Title of policy: Standing Orders (SO's) and Standing Financial Instructions (SFI's) for the Cwm Taf University Health Board (CTUHB)

Section 1: Preparation

Section 1 – Preparation		
1.	**Title of Policy**	Standing Orders (SO's) and Standing Financial Instructions (SFI's) for the Cwm Taf University Health Board (UHB).
2.	**Policy Aims and Brief Description** -	All statutory NHS bodies in Wales must agree Standing Orders (SO's) that, together with a set of Standing Financial Instructions (SFI's) and a scheme of decisions reserved to the Board; a scheme of delegations to officers and others; and a range of other framework documents set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities - its 'ways of working'. The Standing Orders are based upon the model determined by the Welsh Government.
3.	**Who Owns/Defines the Policy?**	Chief Executive, CTUHB Chair, CTUHB Executive Board, CTUHB Director of Corporate Services & Governance / Board Secretary
4.	**Who is Involved in undertaking this EqIA?**	The standing orders are based on the Welsh Government Model document and therefore this will have already been scrutinised under the Welsh Government EIA process. However the following policy makers will be consulted on the draft document: Chief Executive, CTUHB Chair, CTUHB Executive Board, CTUHB Director of Corporate Services & Governance / Board Secretary Audit Committee
5.	**Other Policies**	The Standing Orders (SO's) and Standing Financial Instructions (SFI's) for the Cwm Taf UHB.

Section 1 – Preparation		
		The NHS Wales Governance e-manual outlines the context and purpose of the documents: http://www.wales.nhs.uk/governance-emanual/standing-orders-nhs-trusts The document is reviewed annually and is a key element of the corporate governance arrangements of the CTUHB and provides assurance that the SO's are compliant with Welsh Government directives and model standing orders, is up to date with emerging legislation and regulatory guidance and ensures consistency in managing the business of Committee.
6.	**What might help/hinder the success of the policy?**	The Standing Orders will be approved by the Audit Committee.
7.	**Is the policy relevant to "eliminating discrimination and eliminating harassment?"**	The Standing Orders apply to all employees irrespective of age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.
8.	**Is the policy relevant to "promoting equality of opportunity?"**	The standing orders treat all employees equally when it applied consistently. All employees can equally access the rights within this policy.
9.	**Is the policy relevant to "promoting good relationships and positive attitudes?"**	The standing orders treats all employees equally when it is applied consistently.

Section 2. Impact
Do you think that the policy impacts on people because of their age? No the policy applies to all employees irrespective of their age.
Do you think that the policy impacts on people because of their caring responsibilities? I,e, would it affect their ability to care for somebody who is primarily dependant on them? No the policy applies to all employees irrespective of caring responsibilities.
Do you think that the policy impacts on people because of their disability? The corporate style guide recommends a font size of 12 in verdana font for corporate documents, which is in accordance with recommended practice for accessible documents. There is a risk that the font size and written format could pose difficulties for readers who have a visual impairment. However, if the document is viewed electronically the resolution of the screen can be increased to enable a larger font view and the document could also be requested in a Braille format, or a large print format on request.
Do you think that the policy impacts on people because of Gender reassignment? As the standing orders apply to all employee irrespective of their gender it should not impact on employees going through gender reassignment. The language throughout the policy is gender neutral.
Do you think that the policy impacts on people because of their being married or in a civil partnership? No the document does not discriminate on any grounds including being married, in a partnership or in a civil partnership.
Do you think that the policy impacts on people because of their being pregnant or having recently had a baby? No, this document will have no impact on people because of their being pregnant or having recently had a baby.
Do you think that the policy impacts on people because of their race? The document does not discriminate on any grounds including race.
Do you think that the policy impacts on people because of their religion, belief or non-belief? The document does not discriminate on any grounds including religion, belief or non-belief.
Do you think that the policy impacts on men and woman in different ways? No, there is no discrimination on the grounds of gender when applied fairly and consistently.
Do you think that the policy impacts on people because of their sexual orientation? The document does not discriminate on any grounds of sexual orientation.
Do you think that the policy impacts on people because of their Welsh language? Cwm Taf UHB is committed to treating the Welsh and English language equally in accordance with the Welsh Language Act 1993 and the Welsh Language (Wales) Measure 2011 and are proactive in ensuring that public facing services and documents are fully bilingual. A Welsh version of the document will be published on the website.

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below.
The right to life The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right not be tortured or treated in an inhuman or degrading way The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right to liberty The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right to a fair trial The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right to respect for private and family life, home and correspondence The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right to freedom of thought, conscience and religion The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act The Cwm Taf UHB supports the fundamental rights and freedoms that everyone in the UK is entitled to outlined within the Human Rights Act 1998 and at present we have not identified any potential adverse impacts in this area.

Section 3 Outcome Report

Policy Title:	**Standing Orders (SO's) and Standing Financial Instructions (SFI's) for the Cwm Taf UHB**
Organisation:	Cwm Taf UHB
Name: **Title:** **Department:** **Date:**	Gwenan Roberts Interim Board Secretary 12 April 2019
Summary of Assessment: **Please indicate issues of significant concern and changes that will be made to the policy accordingly.** **Please indicate whether these changes have been made.**	No potential adverse impacts have been identified at present. The document will be issued in an electronic format only and no paper copies will be distributed. Hard copies will be provided on request and will be printed on double sided paper on recycled paper.
Monitoring Arrangements:	The document will be reviewed annually.
Review Date: This is usually the same as the policy review date	The Standing Orders will be reviewed on an annual basis.
Signature of all Parties:	Gwenan Roberts

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board	**AGENDA ITEM 3.1** **1 April 2019**

Audit Committee Report
CHARITABLE FUNDS

Executive Lead: Director of Finance
Author: Head of Finance
Contact Details for further information: Huw Evans on 01443 443810 or huw.evans2@wales.nhs.uk

Purpose of the Audit Committee Report
To advise the Audit Committee of the activity and balances on charitable funds for the period 1 December 2018 to 28 February 2019 and provide an update on the transfer of balances associated with the Bridgend Boundary Change.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2018-2021 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Triple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient • Experience • To **protect** and **improve** population health • To **ensure** that the services provided are • accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. The main aim of this report is to improve governance and assurance.
Supporting evidence	N/A

Engagement – Who has been involved in this work?
Finance Workstream – Bridgend Boundary Change Project

Audit Committee Resolution to:							
APPROVE	√	**ENDORSE**	√	**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is requested to: • **NOTE** the current balances and investment performance of Cwm Taf funds • **NOTE** the process for determining funds to be transferred, and their balances at 31.12.18 • **APPROVE** the actions proposed for registering the name change and revised objects with the Charity Commissioner • **ENDORSE** the increase in staffing resources required to administer the additional funds being transferred						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	There are no specific equality and diversity issues
Legal implications	Charitable funds are required to be managed in accordance with charity legislation and requirements of the Charity Commissioner.
Population Health	No specific population health issues
Quality, Safety & Patient Experience	No specific quality, safety or patient experience issues
Resources	Investment of surplus funds assists in maximising income whilst safeguarding funds
Risks and Assurance	The report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund.
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. The work reported in this summary takes into account many of the related quality themes.
Workforce	No specific workforce implications
Freedom of Information Status	Open

CHARITABLE FUNDS

1. SITUATION / PURPOSE OF REPORT

To advise the Audit Committee of the activity and balances on charitable funds for the period 1 December 2018 to 28 February 2019. The report also provides an update on the transfer of balances associated with the Bridgend Boundary Change from 1 April 2019.

2. BACKGROUND / INTRODUCTION

The previous report to the Audit Committee highlighted balances and transactions up to 30 November 2018. This report updates the position as at 28 February 2019 and provides further analysis over their use by both fund type and location. An update is also provided on the investment performance, and impact of Bridgend Boundary Change.

BALANCES HELD BY THE CHARITABLE FUND

Balances held by the Charitable Fund as at 28 February 2019 are summarised in **Appendix A** analysed by fund type and location. Income received and expenditure incurred during the period 1 December to 28 February is also shown.

The balance at the end of February is £1.852m which is an increase of £10k since the last report (30.11.18).

These balances exclude the unrealised gain on investment referred to below.

LOW VALUE AND SLOW MOVING FUNDS

A listing of all funds below £1,000 as at 28 February 2019 is shown in **Appendix B.**

It should be noted that certain funds with low balances are very active and are being constantly used. This meets the objective of using funds for the purposes intended rather than allowing balances to accumulate. Also shown therefore within **Appendix B** are those funds with higher balances where there has been no expenditure activity during the previous six months.

The usual comments on each of these funds have not been included in this report due to workload pressures, particularly in light of the additional Bridgend activity (see below). These will be incorporated into future reports as normal.

INVESTMENT

The total units held remain at 783,307.83.

The market value at 28 February was £1.790m (a fall of £20k from the end of November), compared to £1.5m invested (i.e. a surplus of £290k – 19.3%).

Due to the volatility of the markets at this time, Trustees decided not to distribute any surpluses to individual funds at its annual meeting in October. Any surpluses will therefore be retained centrally as a buffer in the event of any future falls in investment values.

Forecast income for 2018-19 remains at £62k – an income yield of 3.5%.

A graphical presentation of the investment performance by week, along with a FTSE100 comparator, is shown in **Appendix C**.

BRIDGEND BOUNDARY CHANGE

a) <u>Funds Earmarked for Transfer</u>

Attached as **Appendix D** is the paper prepared by Abertawe Bro Morgannwg University (ABMU) Health Board to the Finance Workstream of the Boundary Change Project following its Charitable Trustees meeting on 31 January 2019.

The recommendation to this paper proposes that details of the funds to transfer are shared with the Cwm Taf Health Board Trustees, noting that the fund balances will be different as at 31 March 2019 when it is hoped that the transfer can take place subject to Charity Commission approval. It was therefore agreed that the paper be included here for information.

Subsequent to the preparation of the ABMU paper, 3 funds originally earmarked for transfer is now likely to remain within ABMU as the associated services are not transferring. These are:

YG17 POW Rheumatology Research	£10,397.22 (as at 31.12.18)
YC19 East Cardiac Rehabilitation	£ 1,678.60 (" ")
YN71 Pulmonary Rehabilitation	£ 1,280.00 (" ")

b) <u>Name Change</u>

The Charity will need to be renamed to Cwm Taf Morgannwg NHS General Charitable Fund from 1 April 2019 to reflect the geography of the population for which it serves, and to be consistent with the Health Board's name change. This will be enacted on the Charity Commissioner's website on 1 April 2019. ABMU will be registering their name change on the same day.

c) Change of Charitable Fund Purposes

The current purposes or objects of the Charity are:

"*The Trustees shall hold the funds upon trust to apply the income, and at their discretion so far as permissible, the capital, for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by Cwm Taf UHB*"

Clearly the name change will need to be reflected in the revised objects. Part of a fund on Africa Health Links is being transferred and we therefore need to ensure that this can continue to be used for the purpose intended. With this in mind it is therefore proposed to amend the objects to incorporate wording currently used within ABMU; namely:

"*The Trustees shall hold the funds upon trust to apply the income, and at their discretion so far as permissible, the capital, for any charitable purpose or purposes relating to the National Health Service (wholly or mainly for the service provided by Cwm Taf* ***Morgannwg*** *UHB)* ***and for any other Health Services for which specific monies have been donated for use within the UK or overseas***"

The incorporation of this additional wording will also enable the Health Board to set up funds in the future in relation to other International Health Links for which donations may be received (e.g. Vanuatu), as well as the Africa Health Links fund being transferred.

Again, this change will need to be registered from 1 April 2019 and synchronised with ABMU. The process can take up to 30 days to be implemented by the Charity Commissioner. A transition plan will therefore need to be agreed with ABMU to ensure funds can be accessed in the interim pending the completion of the registration process. **The Charity Commissioner may require a copy of the minutes of the Committee being asked to approve this change**, **and a Supplemental Deed may be required to be signed by the Chair of the Health Board on behalf of Trustees.** This will be further discussed with ABMU and Charity Commissioner to ensure consistency of approach.

d) Staffing Resources

Clearly, the incorporation of these additional funds substantially increases the administrative work for Cwm Taf Morgannwg UHB. This cannot be undertaken within existing staff resources where the only dedicated staff support is a part time band 5 post within the Finance Department.

It is therefore proposed to add a full time band 3 post to the establishment to help deal with the extra workload relating to funds being transferred. The cost of this will be in the region of £23k and will need to be charged against charitable funds. Investment of around £750k of the funds being transferred into the existing ethical fund being used by Cwm Taf UHB would generate additional income of approximately £30k which will more than offset the increase in administrative costs. This has been approved by the Director of Finance and Chief Executive, and therefore needs endorsement by the Audit Committee.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

This report is a key element of the charitable funds governance and assurance process, and which enables Trustees' to discharge their responsibilities over the management of the charitable fund. It also demonstrates due process around the transfer of funds from ABMU and the setting up of arrangements moving forward post the boundary change

4. RECOMMENDATION

The Audit Committee is requested to:

- **NOTE** the current balances and investment performance of Cwm Taf funds
- **NOTE** the process for determining funds to be transferred, and their balances at 31.12.18
- **APPROVE** the actions proposed for registering the name change and revised objects with the Charity Commissioner
- **ENDORSE** the increase in staffing resources required to administer the additional funds being transferred.

Freedom of Information Status	Open

APPENDIX A

Summary of Funds and Transactions 01.04.18 - 28.02.19

No of Funds 31.03.17	No of Funds 31.03.18	No of Funds 28.02.19		Previous Period(s) Balance 31.03.18 £	Income £	Expend. £	Revised Balance £	Income Dec-Feb £	Expend Dec-Feb £	Balance 28.02.19 £
A			**By TYPE**							
10	10	10	General Purposes	444,335.88	15,294.18	(14,820.94)	444,809.12	3,492.57	(14,593.25)	433,708.44
65	62	58	Specific Purposes	1,159,581.84	59,328.50	(80,544.23)	1,138,366.11	29,500.75	(9,758.62)	1,158,108.24
5	5	5	Post Graduate Education	35,194.64	300.00	(2,186.07)	33,308.57	0.00	(5,481.76)	27,826.81
13	13	13	Research	248,587.40	4,596.95	(28,026.00)	225,158.35	12,927.00	(5,464.21)	232,621.14
93	**90**	**86**	**Total**	**1,887,699.76**	**79,519.63**	**(125,577.24)**	**1,841,642.15**	**45,920.32**	**(35,297.84)**	**1,852,264.63**
B			**By Location**							
33	32	31	RGH	264,692.22	8,036.60	(10,141.50)	262,587.32	9,539.00	(4,129.12)	267,997.20
17	15	15	PCH	409,986.32	28,117.98	(76,085.97)	362,018.33	23,104.21	(14,934.47)	370,188.07
9	11	11	RGH/PCH Combined	478,767.32	19,468.64	(6,811.47)	491,424.49	4,486.00	(1,906.09)	494,004.40
7	6	6	YCR	28,473.59	3,211.60	(3,331.86)	28,353.33	1,094.86	(656.00)	28,792.19
6	6	6	YCC	312,404.46	16,769.18	(17,935.94)	311,237.70	3,618.50	(6,201.02)	308,655.18
1	1	1	Dewi Sant	565.52	0.00	0.00	565.52	26.00	0.00	591.52
1	1	1	Y Bwthyn	62,799.90	665.00	(2,011.32)	61,453.58	0.00	0.00	61,453.58
4	3	1	YGT	5,269.46	645.00	(2,361.00)	3,553.46	1,350.00	(97.04)	4,806.42
5	5	5	Mental Health Unit	17,088.44	2,487.10	(2,710.82)	16,864.72	2,607.80	(6,474.00)	12,998.52
1	1	1	CAMHS	10,566.07	47.02	0.00	10,613.09	33.95	(225.00)	10,422.04
4	4	3	Community	10,419.37	0.00	0.00	10,419.37	60.00	0.00	10,479.37
3	4	4	LHB Wide	286,667.09	71.51	(4,187.36)	282,551.24	0.00	(675.10)	281,876.14
1	1	1	Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
92	**90**	**86**		**1,887,699.76**	**79,519.63**	**(125,577.24)**	**1,841,642.15**	**45,920.32**	**(35,297.84)**	**1,852,264.63**

Low Value and Slow Moving Funds

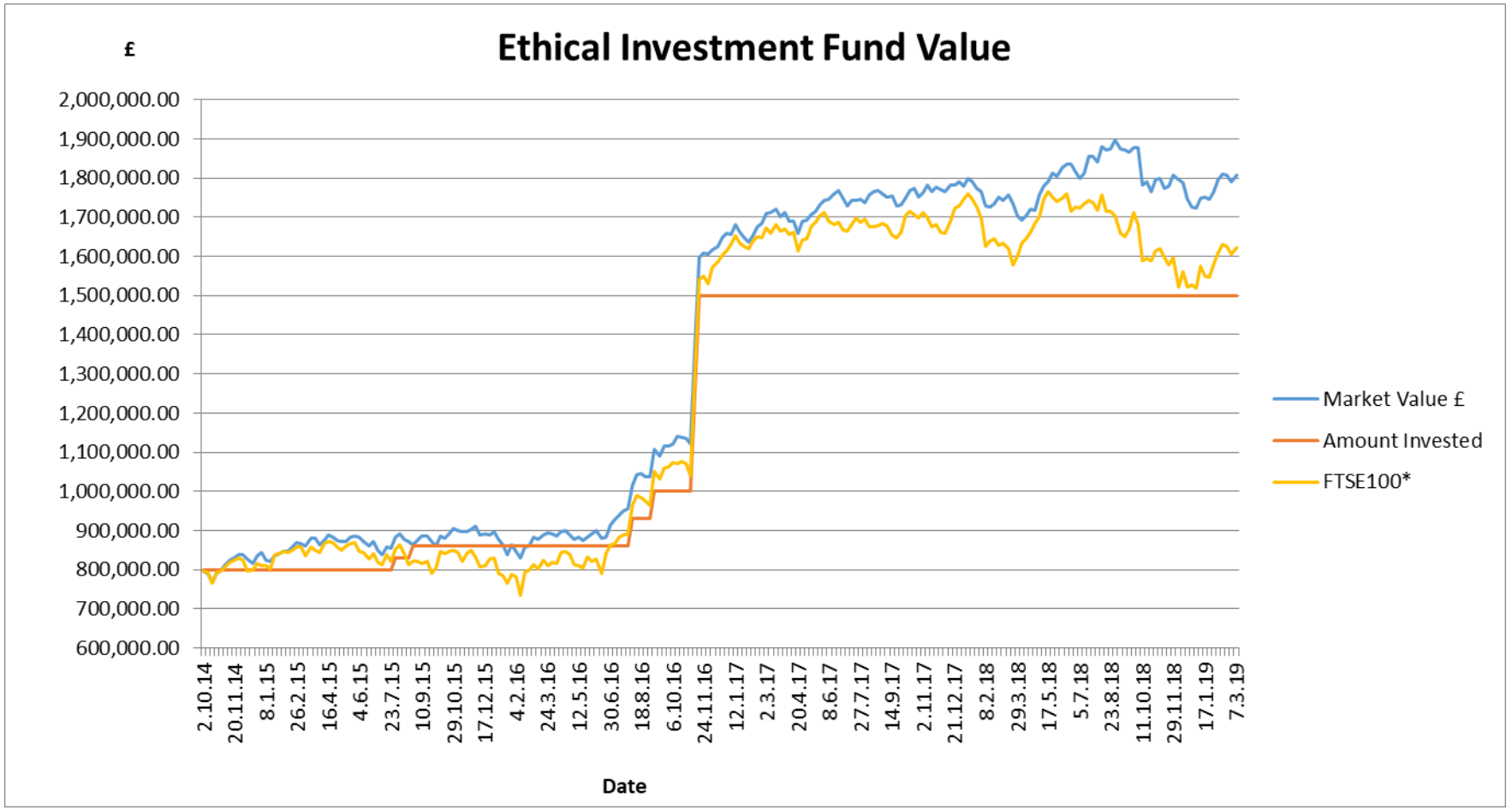
A **Low Value Funds** **Definition - fund balances below £1,000 as at 28.02.19**

Fund No	Fund Type	Location	Balance as at 28.02.19
9422	Post graduate Education	Mental Health Unit	639.60
9423	Post graduate Education	Mental Health Unit	514.81
9459	RESEARCH	RGH	862.63
9465	RESEARCH	RGH	605.43
9483	Specific Purposes	RGH	870.80
9506	RESEARCH	RGH	207.74
9507	RESEARCH	RGH	339.93
9516	Specific Purposes	RGH	56.36
9519	Specific Purposes	RGH	902.05
9604	Specific Purposes	Dewi Sant	591.52
9680	Specific Purposes	YCR	703.16
9824	Specific Purposes	RGH/PCH Combined	936.94
9826	RESEARCH	PCH	368.28
9850	Specific Purposes	LHB WIDE	302.33
9874	Specific Purposes	YCC	302.78

B **Low Activity Funds** **Definition - balance over £1k but no expenditure against fund in last 6 months**

Fund No	Fund Type	Location	Balance as at 28.02.19
9450	General Purposes	RGH	41,802.12
9453	Specific Purposes	RGH	1,291.85
9455	Specific Purposes	RGH	52,721.88
9456	Specific Purposes	RGH	1,397.71
9460	Specific Purposes	RGH	14,944.26
9463	Specific Purposes	PCH	9,769.29
9470	Specific Purposes	RGH	3,029.15
9472	Specific Purposes	RGH	3,904.86
9479	Specific Purposes	RGH	5,603.07
9481	Specific Purposes	RGH	4,906.72
9482	Specific Purposes	RGH	2,385.78
9486	Specific Purposes	RGH	3,061.96
9494	RESEARCH	RGH	12,639.11
9497	Specific Purposes	RGH	5,920.73
9499	RESEARCH	RGH/PCH Combined	14,049.03
9505	RESEARCH	RGH	4,344.07
9510	Specific Purposes	RGH	1,583.63
9517	Specific Purposes	RGH/PCH Combined	15,384.24
9521	Specific Purposes	RGH	21,000.94
9650	General Purposes	Community	2,411.74
9681	Specific Purposes	YCR	1,045.18
9730	General Purposes	Community	6,678.15
9731	Specific Purposes	Community	1,389.48
9801	Specific Purposes	PCH	31,946.28
9803	Specific Purposes	PCH	5,453.14
9809	RESEARCH	PCH	11,026.19
9835	RESEARCH	PCH	66,627.05
9827	Specific Purposes	PCH	7,434.94
9829	Specific Purposes	RGH	6,691.52
9885	General Purposes	LHB WIDE	4,082.07
9888	Specific Purposes	YCC	7,163.77
9891	Specific Purposes	YCC	1,500.94
9900	Specific Purposes – Giving to Pink	RGH/PCH Combined	287,334.02

APPENDIX C


Ethical Investment Fund Value
£
2,000,000.00
1,900,000.00
1,800,000.00
1,700,000.00
1,600,000.00
1,500,000.00
1,400,000.00
1,300,000.00
1,200,000.00
1,100,000.00
1,000,000.00
900,000.00
800,000.00
700,000.00
600,000.00
2.10.14
20.11.14
8.1.15
26.2.15
16.4.15
4.6.15
23.7.15
10.9.15
29.10.15
17.12.15
4.2.16
24.3.16
12.5.16
30.6.16
18.8.16
6.10.16
24.11.16
12.1.17
2.3.17
20.4.17
8.6.17
27.7.17
14.9.17
2.11.17
21.12.17
8.2.18
29.3.18
17.5.18
5.7.18
23.8.18
11.10.18
29.11.18
17.1.19
7.3.19
Date
Market Value £
Amount Invested
FTSE100*

APPENDIX D

Newid ffin Pen-y-bont ar Ogwr



Bridgend boundary change

Title: Charitable Funds Transfers arising from Bridgend Boundary Change Purpose

The purpose of this report is to provide details to the Finance Workstream of the charitable funds to transfer to the Cwm Taf Health Board Charity as a consequence of the Bridgend boundary change. The list of funds to transfer and the methodology to be used where charitable funds require to be split between the ABMU Health Board Charity and the Cwm Taf Health Board Charity was agreed at a meeting of the ABMU Health Board Charity Trustees on 31st January 2019.

Background

As of 1st April 2019, the services provided on behalf of the Bridgend population will transfer to Cwm Taf Health Board from ABMU Health Board. Where services transfer then any charitable funds associated with those services will also transfer. An exercise has been undertaken to determine the funds that will need to transfer, the funds that will remain in ABMU and those that need to be split between the two health board charities.

Whilst the majority of charitable funds can be identified as fully transferring or fully remaining, there are funds which need to be split as they cover either the whole of the ABMU Health Board Charity or the former Bro Morgannwg Trust area (Neath and Bridgend). Each of these funds has been reviewed individually with the fund managers and the methodology as detailed below was agreed with the fund managers and by the Charitable Fund Trustees to enable the balances as at 31st March 2019 to be split and the formal transfer of the fund balances to take place.

The table below shows the high level analysis of the ABMU Health Board Charitable Funds, detailing the number of funds that will transfer, remain or need to be split, together with the fund balance as at 31st December 2018. The detailed listing of all funds is shown in the separate attachment.

APPENDIX D

	Number	Balance as at 31st December £
Funds to Remain with ABMU	269	5,009,166
Funds Transferring to Cwm Taf	67	1,165,344
Funds To be Split	10	453,554
Fund to be merged into Glanrhyd General Purpose Fund and then transfer	1	3,776
Total	**347**	**6,631,840**

As detailed in the table above, the balance of funds at the end of December which have been identified as definite transfers to Cwm Taf Health Board amounts to £1,165,344. There are 10 funds to be split and these are detailed in the table below, together with the methodology agreed by the Trustees for splitting the fund balance.

Fund Name	31st December Balance (£)	Agreed Methodology to Split the Fund
Y664-Charitable Funds Committee Fund	319,798.65	The fund was built up from dividends and interest on the investment portfolio, held by the former Swansea NHS trust, with the benefits being seen across the health board. The Trustees then realised £500k of gains from the portfolio and credited to the fund the bank account interest and also charged to the fund all bank charges, investment management fees, audit fees and Just Giving fees. The investment portfolio covers only the Swansea element and so will remain with ABMU with the bank account interest being allocated to CTU, the amount corresponding to the interest earned since the fund was created. It must be noted that this fund balance is expected to reduce significantly by 31st March given the commitments already made from the fund for 2018/19. (see separate analysis)
Y667-Africa Health Links	42,535.82	To be split based on whether staff contributing to the fund are transferring to CTU or remaining in ABMU. Based on an initial cost centre analysis of staff donating as at December, the share is 73% ABMU and 27% CTU. This can only be confirmed once the final staff transfer list is agreed.
YD06-East Pharmacy Development Fund	788.95	Covers Neath Port Talbot & Bridgend. Fund manager and Trustees agree that a 50/50 split of fund is fair

APPENDIX D

Fund Name	31st December Balance (£)	Agreed Methodology to Split the Fund
YH02-West Maternity	16,949.25	Although an old Swansea Trust Fund, the fund has been used health board wide since 2010. An analysis of the source of donations is inconclusive so split agreed with fund manager and Trustees of 72:28 in accordance with the allocation split
YH47-East Family Planning Fund	30,088.23	Fund covers both Neath and Bridgend. An analysis of the source of donations is inconclusive so split agreed with fund manager and Trustees of 50:50
YK59-East Stroke & Vascular	4,224.55	Fund covers both Neath and Bridgend. An analysis of the source of donations is inconclusive so split agreed with fund manager and Trustees of 50:50
YN56-Paediatric Physiotherapy	16,369.08	Fund has been used as a health board wide fund and so needs to be split. Analysis of the source of donations shows a 92% share for Swansea and Neath Port Talbot and 8% share for POW. The Trustees agreed to split the fund on this basis.
YN58-Occupational Therapy	18,155.14	Fund has been used as a health board wide fund and so needs to be split. Analysis of the source of donations shows a 63% share for Swansea and Neath Port Talbot and 37% share for POW. The Trustees agreed to split the fund on this basis.
YN59-East Community General Purposes	2,965.36	The fund has been used health board wide since 2010. An analysis of the source of donations is inconclusive so split agreed with fund manager and Trustees of 72:28 in accordance with the allocation split
YN67-East Startwell	1,679.14	Fund covers both Neath and Bridgend. An analysis of the source of donations is inconclusive so split agreed with fund manager and Trustees of 50:50

As the former Bro Morgannwg Trust Charitable Funds which transferred into the ABMU Trust in 2008 were held in cash, all balances to transfer will be in the form of a cash transfer to CTU from ABMU.

APPENDIX D

The ABMU Health Board Charity has instructed its investment managers to release £1m from the investment portfolio over the next few weeks to provide sufficient cash for transfer to the Cwm Taf Health Board Charity at the point that the Charity Commission approves the formal funds transfer. The ABMU Health Board charity will bear the consequences of the potential realised losses from the sale of investments in the current market conditions arising as a result of the Brexit uncertainty.

Recommendations

The Finance Workstream is asked to note the details of the charitable funds to transfer from the ABMU Health Board Charity to the Cwm Taf Health Board Charity as agreed by the ABMU Health Board Charity Trustees.

It is proposed that CTU colleagues share the details of the funds to transfer with the Cwm Taf Health Board Trustees, noting that the fund balances will be different as at 31st March 2019 when it is hoped that the transfer can take place subject to Charity Commission approval.

ABMU Charitable Funds Analysis as at 31.12.18

Cost Centre	Fund Purpose
Y602-West Manual Handling	Equipment and Training
Y606-West Resuscitation	Equipment and Training
Y620-West Post Grad Dental	Training
Y621-West Post Grad Hospitality	Training
Y629-East Trust Medical Postgraduate	General
Y630-East GP Tutors Accounts	General
Y633-East GP Tutors Accounts - Neath Port Talbot	General
Y646-Morriston General Patients & Staff	General
Y653-Singleton General Purpose	General
Y654-Finance Admin	General
Y660-ABM Spiritual Care Trust	General
Y664-Charitable Funds Committee Fund	General
Y667-Africa Health Links	General
Y668-West Gastroenterology/Nutrition Fund	General
Y669-West Vascular Surgery Fund	Equipment, Research and Training
Y670-Ward B2 Neath Port Talbot	Patient Care
Y689-Neath Port Talbot General Purpose	General
YA02-POW Intensive Care	General
YA05-POW Theatres Fund	General
YA09-Acute Pain Management Fund	General
YA10-Neath Port Talbot Day Surgery Unit	General
YA11-POW Day Surgery	General
YA12-East Opthalmology Day Surgery Fund	General
YA13-West Anaesthetics Education & Research	Training
YA17-Chronic Pain Fund	Equipment, Patient Care and Training
YA19-West ITU Consultants	Equipment and Training
YA20-West ITU	General
YA21-West HDU	General
YA22-West Theatre Services	Equipment, Patient Care and Training
YA23-West Surgical M R Morgan	Equipment and Training
YA24-Macs Childrens	Patient Care
YB02-West Leukaemia	Patient Care, Research and Training
YB04-Ty Olwen Day Centre	Equipment and Patient Care
YB05-Ty Olwen Education	Training
YB16-Kevin Blakeman	General
YB17-West Bone Marrow Unit	Patient Care, Research and Training
YB21-West Medical Genetics	Training
YB24-West Haematology Patient Support	Training
YB27-West Gynae Cancer & Oncology	General
YB32-GWAED	Patient Care and Training
YB34-Cancer Centre	General
YB36-West Haematology Development	Research and Training
YB39-West Traumatic Brain Injury Service	Equipment, Training and Patient Care

YB40-POW Breast Cancer Fund	General
YB41-Y Bwthyn Newydd	General
YB42-Y Rhosyn Palliative care	General
YB44-Swansea Myeloma Fund	Research
YB45-Tom's Trust Fund (Traumatic Brain Injury Service)	Patient Care
YB46-Jill Rowe Neuro Ambulatory Unit Fund	Equipment, Patient Care and Training
YC01-West CCU Patients & Staff	Patient Care and Staff Benefit
YC02-West Cardiac Research	Equipment, Research and Training
YC04-West Cardiac (K.Evans)	Equipment and Patient Care
YC05-West Coronary Care	Equipment, Patient Care and Training
YC06-West Cardiac Centre	Equipment, Patient Care and Training
YC07-Dan Danino Ward Morriston	Equipment, Patient Care, Training and Staff Benefit
YC08-Cyril Evans Ward Morriston	Equipment, Patient Care, Training and Staff Benefit
YC09-Cardiac ITU Morriston	Equipment, Patient Care and Training
YC10-West Cardiothoracic Surgery	Equipment, Research and Training
YC11-West M Anderson Cardiology	General
YC12-West Cardiac Research	Research, Training and Staff Benefit
YC13-West Dr Jenkins Cardiology	Research and Training
YC14-West Echo	Training
YC15-West Cardiac Health team	General
YC16-West ECG	Training, equipment , furniture
YC17-East Cardiac Fund	General
YC18-East Chest Fund	General
YC19-East Cardiac Rehabilitation	General
YC21-POW ECG Fund	General
YC22-POW Cardiology Study Fund	Training
YC23-POW Cardiac Rehabilitation Fund	General
YC24-East Cardiac Catheter Laboratory	General
YC25-Sarah Boulton Memorial GUCH Fund	Patient Care, Training, Staff Benefit and Research
YC26-Thoracic Surgery Fund	Patient Care and Staff Benefit
YD02-East Breast Radiology Fund	General
YD04-East Radiology/Endoscopy at social	General
YD05-POW Pharmacy	General
YD06-East Pharmacy Development Fund	General
YD08-West Gastroenterology	Equipment and Training
YD10-West Endoscopy Education & Equipment Fund	Equipment and Training
YD11-West Audiology	Equipment and Training
YD12-West MPCE Cancer Research	Research
YD13-West Medical Physics	Research and Training
YD14-West Pharmacy	Equipment and Training
YD15-CC Pharmacy	Equipment and Training
YD17-West Radiology Dept	Equipment and Training
YD19-West BP Imaging	Equipment, Patient Care and Training
YE01-Ward G Morriston	Equipment, Patient Care and Staff Benefit
YE02-Ward H Morriston	Equipment
YE03-Stuart Winsey Surgical Travel	Research and Training
YE04-Breast of Friends - Singleton	Patient Care
YE05-West Centre Digestion Disorders & Nutrition (CDI	Equipment, Research and Training
YE06-MN Ward V Patients & Staff	General
YE08-West GI Research	Research
YE10-West Upper GI	Equipment and Training
YE11-West Breast Care Centre	Patient Care and Training

YE13-Morriston Ward R	Equipment, Patient Care and Training
YE16-West UK Surgical Fund	Equipment, Staff Benefit and Training
YE17-West Continence	Patient Care and Staff Benefit
YE18-West Urology	Equipment, Patient Care, Research and Training
YE20-West Prostate Cancer Research	Research and Training
YE21-Singleton Paediatric Continence	Patient Care and Training
YE22-West Higher Surgical Trainees	Patient Care and Training
YE24-West Stoma Care	General
YE25-West Breast Reconstruction	Training
YE27-Neath Port Talbot General Surgery Fund	General
YE28-POW Ward 7 and Ward 8	General
YE29-POW General Surgery Fund	General
YE30-POW Urology	General
YE34-POW Upper GI	General
YF01-Morriston Clinical Decision Making Unit	Equipment, Patient Care and Training
YF02-Morriston Ward C	Equipment
YF03-Morriston Ward D	Equipment, Patient Care and Training
YF04-Morriston Gowers Ward	Equipment, Patient Care and Training
YF05-Morriston Ward S	Equipment, Patient Care and Training
YF06-West Chest	Equipment and Training
YF08-West Respiratory Care	General
YF09-West Medical Student Examination	Training
YF10-Morriston A & E	General
YF11-Morriston A & E Nurse Education	Training
YF12-Singleton Hospital Diabetic Unit Fund	Equipment and Training
YF13-West Diabetic Endocrine Research	Research and Training
YF14-West Dermatology	Research and Training
YF15-West Diabetic	Equipment
YF16-West Endocrine Research	Equipment, Research and Training
YF17-Singleton Ward 9 Patients & Staff	Equipment
YF18-Singleton Ward 6 Patients & Staff	Patient Care and Training
YF19-Singleton Ward 8 Patients & Staff	Patient Care and Training
YF20-Singleton Ward 10 Patients & Staff	Patient Care and Training
YF21-West GI Research	Research and Training
YF22-West Endocrine Specialist Nurse	Patient Care and Training
YF25-Singleton Medical Assessment Unit	Equipment, Patient Care and Training
YF26-West Diabetes Unit Development	Equipment, Patient Care and Training
YF27-West Renal Dialysis Research	Research
YF28-West Renal Dialysis Unit	Patient Care
YF29-West Renal Medical Ward	Equipment, Patient Care and Training
YF30-West Renal Unit Education	Training
YF31-West Neurology	Equipment and Training
YF32-Neurology Education & Patient Equipment	Equipment and Training
YF33-West Parkinson's Disease	Equipment, Patient Care and Training
YF34-West Epilepsy Service	General
YF35-West MS Specialist Team	Equipment, Patient Care and Training
YF36-West Clinical Neurophysiology Charitable Fund	Equipment and Training
YF37-Renal Dialysis UNIT Endowment	General
YF38-Neath Port Talbot MIU Fund	General
YF39-POW A&E Fund	General
YF40-Neath Port Talbot Diabetic Fund	General
YF41-NPTH Endoscopy Fund	Equipment and Training
YF42-NPTH Stroke Fund Ward B2	Patient Care

YF45-East Dermatology	Research
YF46-POW Diabetic Adults	General
YF47-POW Ward 5 and Ward 6	General
YF48-POW Ward 2 and Ward 10	General
YF49-POW Cardiac Care Unit Ward 4	General
YF51-POW Gastroenterology	General
YF56-East Respiratory Fund	General
YF58-East Anticoagulation Fund	General
YF59-East Fast Track Unit Fund	General
YF60-Neath Port Talbot Wards	General
YF66-Melanoma and Skin Cancer	Equipment and Training
YF68-SN Ward 4	Equipment, Patient Care, Training and Staff Benefit
YF69-GP Out of Hours Fund	General
YF70-Bevan Legacy Fund	Training
YF71-Renal Annexe	Equipment
YG01-West Arthritis	Research and Training
YG02-West Rheumatology	Research and Training
YG03-West Orthopaedic	General
YG05-Morriston Ward A	Equipment
YG06-Morriston Ward J	Equipment
YG07-West Trauma Unit	Equipment, Patient Care, Training and Staff Benefit
YG08-West Paediatric Ortho Develop	Equipment and Training
YG09-Morriston Ward B Trauma & Ortho Surgery	Equipment and Staff Benefit
YG12-West Arthroplasty Pre-admission Edu	Training
YG17-POW Rheumatology Research	Equipment, Patient Care, Research and Training
YG18-Ward B2 Neath Port Talbot - Staff Fund	Staff Benefit
YG19-Arthroplasty Educational Support Fund	Training
YH01-West Consultant Nurse & Midwife Cymru Confere	Training
YH02-West Maternity	General
YH04-West Mr Emery Gynaecology	Research and Training
YH07-West Gynaecology	General
YH08-West GUM Clinic	Patient Care, Training and Staff Benefit
YH11-West Obs & Gynae Teaching	Equipment
YH14-West TEDI	Patient Care and Training
YH15-West Integrated Sexual Health	Training
YH16-West Children's	Equipment and Training
YH19-West NICU	Equipment and Training
YH21-West Childrens Diabetes	Patient Care
YH22-SN NICU Education Fund	Equipment and Training
YH24-West NICU Staff Study	Training
YH25-West Paediatric Nutrition	Equipment, Patient Care and Training
YH26-West Paediatric Allergy	Equipment and Training
YH28-West S.H.I.P.S.	Equipment and Patient Care
YH29-West Childrens Cystic Fibrosis	Equipment and Training
YH31-West Childrens Neurology	Equipment, Patient Care and Training
YH32-West Cartref	Equipment, Patient Care and Training
YH33-Scott McCrorie Nurses Study	Training
YH36-West Health Visiting	Equipment, Patient Care and Training
YH37-East Children's Ward	General
YH39-East Obs & Gynae	General
YH40-Port Talbot Gynae Fund	General
YH41-POW S C B U	General
YH42-POW Paediatric	General

YH43-East Infertility & Gynaecology	General
YH47-East Family Planning Fund	General
YH49-East OD & T Fund	General
YH50-East Paediatric CF Fund	General
YH53-Paediatric Endocrine Fund	General
YH54-O&G STC Fund	Training
YJ01-West Haematology & Leukaemia	Patient Care and Training
YJ02-West Histo/Cytopathology	Research and Training
YJ03-ABMU Pathology West General Purpose Fund	General
YJ05-West Sanguine	Training
YJ10-ABMU Pathology East General Purpose Fund	General
YK02-West Mastectomy	Equipment, Patient Care and Training
YK03-West ENT Support	Equipment, Patient Care and Training
YK04-Singleton Ward 2 Patients & Staff	Equipment and Patient Care
YK05-West ENT Fund	Patient Care
YK06-West ENT Book	Training
YK07-West Otolaryngology	General
YK08-West ENT OPD	Equipment and Training
YK09-West ENT Respiratory Symposium	Research and Training
YK10-West ENT STB	Equipment and Training
YK11-West Cleft & Lip Palate Team	General
YK12-West Oral Surg Dental Research	General
YK14-West Craniofacial Implant	General
YK15-MN SLH Maxillofacial Research and General	Research and Training
YK16-West Orthodontics	General
YK17-West Max Facial Research No 2	Research and Training
YK18-West Maxillofacial Ward	General
YK19-West Lets Face It	Equipment and Training
YK20-West Maxillofacial Res Sec	Research and Training
YK23-West Maxillofacial Dept Educ & Equi	Equipment and Training
YK24-West Clinical Implant Co-Ordinator	Research and Training
YK25-West Restorative Dentistry - J Owen	Training
YK26-West CARTIS	General
YK27-West Ophthalmic Equipment	Equipment and Patient Care
YK28-West Ophthalmic Education	Research and Training
YK29-West Childrens Eye	Equipment, Research and Training
YK30-West Ophthalmic General Purpose	Training
YK31-West Eye T	Equipment and Training
YK33-West Burns Unit	Equipment and Training
YK34-B & P ITU Tempest Ward	General Purpose
YK35-Morriston Pembroke Ward	Equipment, Patient Care, Training and Staff Benefit
YK37-Morriston Clydach Ward	Equipment and Training
YK38-Morriston B & P OPD	Equipment and Patient Care
YK39-Morriston Powys Ward	Equipment, Patient Care and Staff Benefit
YK40-Welsh Burns & Plastics Unit - Stickler Fund	Research and Training
YK42-Morriston Dyfed Ward	Equipment, Patient Care and Training
YK43-Welsh Dragon Burns Club	Equipment and Patient Care
YK44-Artificial Limb & Appliance Centre	Patient Care
YK47-Spinal Surgery Educational Fund	Equipment, Research and Training
YK48-Debbie's Nurse Education	Training
YK51-Neath Port Talbot Mastectomy Fund	General
YK52-POW ENT Fund	General
YK54-POW Orthopaedic Ward	General

YK55-POW Opthalmology Fund	General
YK58-East Opthalmology Glaucoma Fund	General
YK59-East Stroke & Vascular	General
YK60-East Health Psychology Tinnitus	General
YK62-SDMU Fund	Patient Care, Training and Staff Benefit
YK63-SWW Motor Neurone Disease (MND) Fund	Equipment, Patient Care and Training
YK64-Anglesey Ward	General
YN01-Morriston Ward F	Equipment and Staff Benefit
YN02-Singleton Ward 3 Patients & Staff	Equipment and Patient Care
YN03-West Elderly Care Functions	Training, study leave, medical & office equipment
YN04-MN Stroke	Training, study leave, medical & office equipment
YN05-Henry Langen Peer Support Fund	General
YN06-Gorseinon Pats Staff	Equipment, Patient Care, Training and Staff Benefit
YN08-Gorseinon West Ward	Equipment, Patient Care, Training and Staff Benefit
YN09-Singleton Ward 7 Patient & Staff	Equipment and Patient Care
YN10-West Elderly Care Research	Research and Training
YN16-Rehab Day Unit (RDU)	Equipment, Patient Care, Training and Staff Benefit
YN20-West Ward W	Patient Care and Training
YN21-NPTH Neuro Rehab Patients & Staff Fund	Equipment, Patient Care and Training
YN22-West Asylum Seeker Health	Patient Care
YN23-West District Nurse Training	Training
YN24-West Spice Development	Patient Care
YN25-Gorseinon District Nurse Comfort	Patient Care and Staff Benefit
YN30-West CREST	Equipment and Training
YN31-West Dept of Nutrition & Dietetics	Training
YN34-West Physiotherapy Fund	Equipment, Patient Care and Training
YN36-West Lymphoedema Clinic	General
YN41-POW Ewenny Ward	General
YN42-POW Medical Day Unit	General
YN43-Afan Nedd Day Unit	General
YN44-Neath Port Talbot Care of the Elderly	General
YN47-Wales Fertility Institute Staff Development Fund	General
YN50-Neath Dietetic Fund	General
YN51-Neath Physiotherapy Fund	General
YN53-Skewen District Nurses Fund	General
YN55-East CHS Speech Therapy Fund	General
YN56-Paediatric Physiotherapy	General
YN57-POW Physiotherapy Dept	General
YN58-Occupational Therapy	General
YN59-East Community General Purposes	General
YN61-Maesteg General Purposes	General
YN64-East Palliative Care	General
YN66-Neath COPD Fund	General
YN67-East Startwell	General
YN68-Pontardawe District Nurses Fund	Equipment
YN69-Bridgend District Nursing Patient Fund	General
YN70-Shickle Fund	Equipment
YN71-Pulmonary Rehabilitation	Equipment and Training
YN72-Palliative Care OT Therapuetic Activities Fund (YBI	General

YP01-POW Chapel	General
YP03-POW General Purpose	General
YP10-League of Friends Neath	Equipment
YP11-League of Friends Port Talbot	Equipment
YP12-League of Friends MN	Patient Care and Staff Benefit
YP13-Friends of SN Hospital	Patient Care and Staff Benefit
YP20-West Catering	Equipment and Training
YP21-Arts in Health	Patient Care
YP23-Morriston Ward T	Equipment, Patient Care and Training
YR01-West Neuropsychology Fund	Equipment and Training
YR02-West Community Drugs Team	Equipment and Training
YR03-Cefn Coed Rehab Servs	Patient Care
YR08-West All Wales Eating Dis Sp Int Gr	Research and Training
YR11-Ty Einon	Patient Care and Training
YR12-Cefn Coed EMI (D)	Patient Care
YR13-Cefn Coed Ward 1 Staff Develop	Patient Care and Training
YR14-Garngoch Pat / Staff	Patient Care
YR15-Garngoch EMI Research	Training
YR17-Cefn Coed Pat / Staff	General
YR18-West Patients Council	General
YR19-Tonna EMI Fund	General
YR20-Tonna EMI Day Hospital Fund	General
YR21-Tonna David Blight Legacy	Equipment and Research
YR23-Coity Clinic Adult General Endowment	General
YR26-Glanrhyd Dr R Colgate Research	General
YR28-Glanrhyd General Purpose	General
YR29-Older Peoples Services Coity Clinic	General
YR31-East Psychology Fund	General
YR34-Glanrhyd CDAT Fund	General
YR35-Port Talbot & Afan Valley Forge Cen	General
YR37-Ward F (Adult) Mental Health NPTH	General
YR38-Ward G (Elderly) Mental Health NPTH	General
YR39-Glanrhyd Angelton Clinic Fund	General
YR40-Glanrhyd Caswell Clinic	General
YR41-Cefn Yr Afon	-
YR42-Psychological Medicine - Liaison	General
YR44-Chronic Conditions Management	Equipment and Training
YT02-Speech Therapy Cleft	General
YT03-West Speech Therapy	Equipment and Training
YT04-Learning Disabilities Patient Fund	General
YT05-Learning Disabilities Directorate Fund	General
YT08-East Llwyneryr Unit	General
YT10-Cardiff Medical Fund	General
YT11-Laurels and Briary Patient Fund	Patients Activities & Welfare
Total	-

Summary of Fund balances as at 31st December

To Remain with ABMU
Transfer to Cwm Taf
To be Split
To be Resolved

Total

	Agreed Outcome				
Period Closing Balance (£) 31.12.18	Remain in ABMU	Tfr to Cwm Taf	Query	To be split	Plans to close
-226.22	✓				
-237.67	✓				
-198.66	✓				
-648.27	✓				
-1,080.35		✓			
-3,130.66		✓			
-781.85	✓				
-6,068.69	✓				
-91,369.02	✓				
-1,697,068.39	✓				
-2,922.62	✓				
-319,798.65				✓	
-42,535.82				✓	
-9,000.76	✓				
-13,293.43	✓				
-1,047.71	✓				
-12,662.35	✓				
-2,726.98		✓			
-165.42		✓			
-1,720.97		✓			
-244.96	✓				
-700.57		✓			
-2,356.80		✓			
-1,168.42	✓				
-1,886.10	✓				
-6,726.90	✓				
-90,329.66	✓				
-37,861.84	✓				
-58.14	✓				
-6,789.85	✓				
-7,369.49	✓				
-31,430.18	✓				
-721.35	✓				
-3,579.26	✓				
-52,267.76	✓				
-6,778.21	✓				
-2,981.43	✓				
-966.22	✓				
-29,288.31	✓				
-15,907.03	✓				
-264,486.88	✓				
-1,747.80	✓				
-6,458.23	✓				

-14,285.03		✓	
-299,066.29		✓	
-54,265.07	✓		
-101,455.65	✓		
-24,868.14	✓		
-4,462.41	✓		
-17,370.19	✓		
-12,748.93	✓		
-9,035.43	✓		
-15,687.08	✓		
-135,275.89	✓		
-11,418.17	✓		
-3,107.34	✓		
-6,400.61	✓		
-33,366.66	✓		
-20,364.02	✓		
-31,914.23	✓		
-7,604.30	✓		
-608.82	✓		
-4,233.21	✓		
-2,636.20	✓		
-8,804.05		✓	
-5,980.57		✓	
-1,678.60		✓	
-224.35		✓	
-32,787.84		✓	
-7,100.85		✓	
-1,228.49		✓	
-7,339.67		✓	
-87.20	✓		
-243.27		✓	
-441.97		✓	
-199.99		✓	
-788.95			✓
-3,193.41	✓		
-980.00	✓		
-10,743.67	✓		
-21,911.22	✓		
-14,824.65	✓		
-815.11	✓		
-233.95	✓		
-302.20	✓		
-111.40	✓		
-12,114.94	✓		
-132.87	✓		
-4,663.13	✓		
-19,168.18	✓		
-19,747.36	✓		
-6,519.70	✓		
-16,462.92	✓		
-60,594.69	✓		
-50,344.10	✓		

-4,382.59	✓	
-2,499.40	✓	
-2,790.45	✓	
-48,298.70	✓	
-56,750.24	✓	
-2,460.13	✓	
-5,945.36	✓	
-4,655.75	✓	
-644.95	✓	
-12,356.29	✓	
-2,779.12		✓
-3,694.18		✓
-1,304.58		✓
-680.14		✓
-1,806.65	✓	
-1,189.30	✓	
1,307.43	✓	
-1,102.42	✓	
-5,642.83	✓	
-25,663.25	✓	
-9,767.62	✓	
-465.76	✓	
-12,894.74	✓	
-10,457.97	✓	
-1,698.55	✓	
-8,858.24	✓	
-484.71	✓	
-25,035.96	✓	
-909.17	✓	
-7,218.43	✓	
-2,799.82	✓	
-3,608.73	✓	
-276.61	✓	
-3,375.12	✓	
-6,005.99	✓	
-567.49	✓	
-16,846.76	✓	
-4,570.55	✓	
-89,868.65	✓	
-10,778.27	✓	
-799.32	✓	
-59,417.59	✓	
-37,318.38	✓	
-85,188.45	✓	
-179.30	✓	
-34,641.99	✓	
-19,143.61	✓	
-19,126.50	✓	
-2,343.12	✓	
-6,939.90		✓
-2,533.87	✓	
-5,575.87	✓	
-1,241.03	✓	

-4,469.08		✓	
-283,672.08		✓	
-8,456.76		✓	
-7,019.67		✓	
-1,667.93		✓	
-16,955.07		✓	
-3,608.87		✓	
-15,176.54		✓	
-1,057.06		✓	
-17,664.19	✓		
-26,120.39	✓		
-2,955.67	✓		
-6,280.60	✓		
-158,459.10	✓		
-4,307.00	✓		
-2,055.81	✓		
-3,033.59	✓		
-336.98	✓		
-1,049.81	✓		
-2,920.36	✓		
-231.91	✓		
-5,121.89	✓		
-1,039.29	✓		
-1,071.70	✓		
-10,397.22		✓	
-2,521.27	✓		
-500.00	✓		
-458.83	✓		
-16,949.25			✓
-2,290.73	✓		
-5,081.91	✓		
-680.97	✓		
-2,406.89	✓		
-2,262.80	✓		
-507.48	✓		
-4,508.01	✓		
-38,397.51	✓		
-5,739.55	✓		
-28,110.43	✓		
-2,226.66	✓		
-3,908.86	✓		
-309.06	✓		
-23,325.14	✓		
-10,870.57	✓		
-11,968.57	✓		
-1,437.14	✓		
-865.13	✓		
-45.55	✓		
-1,778.19		✓	
-759.13		✓	
-290.08	✓		
-14,982.28		✓	
-50,214.44		✓	

-643.64	✓		
-30,088.23			✓
-1,776.91		✓	
-788.10		✓	
-2,461.05		✓	
-24,088.63	✓		
-13,925.29	✓		
-828.04	✓		
-1,742.35	✓		
-779.70	✓		
-698.35	✓		
-111,765.70	✓		
-2,327.04	✓		
-1,525.95	✓		
-2,218.97	✓		
-3,042.30	✓		
-17,951.15	✓		
-832.52	✓		
-2,519.16	✓		
-3,523.82	✓		
-22,275.84	✓		
-7,264.94	✓		
-5,751.34	✓		
-3,162.87	✓		
-1,387.75	✓		
-869.63	✓		
-446.62	✓		
-9,410.10	✓		
-12,405.53	✓		
-8,043.90	✓		
-18,050.20	✓		
-12,301.38	✓		
-3,405.22	✓		
-11,539.39	✓		
-3,995.21	✓		
-2,980.99	✓		
-9,307.48	✓		
-990.42	✓		
-6,345.64	✓		
-9,169.07	✓		
-7,222.42	✓		
-2,554.88	✓		
-1,564.11	✓		
-4,190.38	✓		
-27,928.91	✓		
-1,616.67	✓		
-46,573.04	✓		
-6,227.56	✓		
-21,438.01	✓		
-14,042.77	✓		
-50,571.62		✓	
-3,683.98		✓	
-1,645.77		✓	

-5,434.58		✓	
-4,692.58		✓	
-4,224.55			✓
-6,530.88		✓	
-1,447.20	✓		
-735.00	✓		
-621.58	✓		
-8,833.98	✓		
-2,146.57	✓		
-2,823.74	✓		
-6,572.23	✓		
-595.00	✓		
-27.84	✓		
-621.83	✓		
-14,462.49	✓		
-10,955.84	✓		
-1,754.00	✓		
-479.52	✓		
-8,050.12	✓		
-81.28	✓		
-644.99	✓		
-18,134.52	✓		
-441.86	✓		
-529.91	✓		
-1,946.85	✓		
-12,564.91	✓		
-13,895.54	✓		
-5,797.88		✓	
-3,258.85		✓	
-60,902.87	✓		
-6,604.31	✓		
-5,280.96	✓		
-673.88	✓		
-6,628.60	✓		
-3,547.91	✓		
-1,254.37		✓	
-16,369.08			✓
-680.00		✓	
-18,155.14			✓
-2,965.36			✓
-206,121.32		✓	
-693.24		✓	
-6,439.91	✓		
-1,679.14			✓
-616.00	✓		
-216.00		✓	
-675.00	✓		
-1,280.00		✓	
-1,857.74		✓	

-1,779.09		✓	
-19,199.83		✓	
2,989.78	✓		
3,314.14	✓		
167.53	✓		
0.00	✓		
-431.97	✓		
-43,157.62	✓		
-467.52	✓		
-1,741.88	✓		
-1,364.36	✓		
-378.24	✓		
-562.84	✓		
-219.74	✓		
-9,043.97	✓		
-783.41	✓		
-15,618.80	✓		
-1,317.54	✓		
-2,639.88	✓		
-31,617.61	✓		
-367.64	✓		
-2,959.53	✓		
-16,911.12	✓		
-179.61		✓	
-806.59		✓	
-1,548.40		✓	
-7,288.16		✓	
-3,776.22			✓
-2,217.65		✓	
-1,096.82	✓		
-155.30	✓		
-934.07	✓		
-3,755.24		✓	
-4,591.83	✓		
-2,500.00		✓	
-449.11		✓	
-67.35	✓		
-1,837.05	✓		
-12,172.41	✓		
-2,873.79	✓		
-232.67	✓		
-5,250.90	✓		
-1,233.51	✓		
-409.65	✓		
-6,631,839.78			

-5,009,165.88
-1,165,343.51
-453,554.17
-3,776.22
-6,631,839.78

APPENDIX D

Comment
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
MPEC so POW and needs to transfer. Being run down no new monies
Old Bridgend Account so needs to transfer
Neath Port Talbot Account and service remaining
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
Contains the realised and unrealised gains & losses from the Investment Portfolio. Portfolio is old Swansea Trust portfolio and has never been added to so all gains and losses relate to Swansea services and remain in ABMU
Fund manager confirms only Swansea area funds in here - PoW monies in YP01
Fund built up from dividends and interest on the investment portfolio, realisation of £500k of gains from the portfolio and bank account interest. Investment portfolio covers only the Swansea element and so should remain with ABMU with the bank account interest being allocated to CTU. POW schemes have been supported from this fund since its creation, despite minimal income coming into the fund from POW funds.
To be split based on whether staff contributing are transferring or remaining.Based on costs centre analysis of staff donating as at December, the share is 73% ABMU and 27% Cwm Taf.
Old Swansea Trust Fund and srvice remaining in ABMU
Old Swansea Trust Fund so remains in ABMU
NPTH - service remaining in ABMU
NPTH - service remaining in ABMU
Transfer
Transfer
POW based service- Transfer
NPTH - service remaining in ABMU
Transfer
POW based service - Transfer
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
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Old Swansea Trust Fund and service remaining in ABMU

Transfer
Transfer
Neath Port Talbot Account - service remaining in ABMU
Old Swansea Trust Fund and service remaining in ABMU
West Fund Traumatic Brain Injuries Service
Remain - Morriston Fund
Old Swansea Trust
Old Swansea Trust Fund so remains in ABMU - Cardiac
Old Swansea Trust Fund so remains in ABMU - Cardiac
Old Swansea Trust Fund so remains in ABMU - Cardiac
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Old Swansea Trust Fund so remains in ABMU - Cardiac
Old Swansea Trust Fund so remains in ABMU - Cardiac
Old Swansea Trust Fund so remains in ABMU - Cardiac
Transfer
Part of POW cardio fund -so will need to transfer
Transfer
Transfer
Transfer
Transfer
Transfer
This was set up as part of Cardio - Stands for Grown Up Congenital Heart Disease under Jonathan Goodfellow so transfers
Morriston Fund
Dr Phillips confirmed it will transfer with the service
Dr Phillips - Old Bridgend & District account - named after directorate - now just radiology which would it needs to transfer
Transfer
Covers Neath Port Talbot & Bridgend. Fund manager believes 50/50 split of fund is fair
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
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Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Fund manager confirmed no breast surgery donation in this fund. Purely NPT patients & should stay in ABMU
Transfer
Transfer
Transfer
Transfer
Morriston Fund
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
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Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Neath Port Talbot Account So will remain
Transfer
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain

Transfer
Transfer
Transfer
Transfer
Transfer
Transfer
Transfer
Transfer
Transfer
Neath Port Talbot Account So will remain
Singeton Fund So will Remain
Singeton Fund So will Remain
Service to Remain in ABMU
Specific Legacy for Neath Port Talbot Hospital so will remain
Morriston Fund
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Transfer
Neath Port Talbot Account So will remain
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Fund has been used health board wide. Donations analysis is inconclusive so proposed split agreed with fund manager of 72:28 in accordance with the allocation split
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
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Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Transfer
Transfer
Neath Port Talbot Account So will remain
Transfer
Transfer

Neath Port Talbot Account So will remain
Fund covers both Neath and Bridgend. Therefore 50:50 split agreed as source of donations is inconclusive.
Transfer
Transfer
Transfer
Singeton Fund So will Remain
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Service to Remain delivered by ABMU via SLA so will remain
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
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Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Breast Care Services to Transfer to CT
Transfer
Transfer

Transfer
Transfer
Fund covers both Neath and Bridgend. Therefore 50:50 split agreed as source of donations is inconclusive.
Transfer
Morriston Fund
Morriston Fund
Morriston Fund
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Fund created in 2017 for neuromuscular services in Swansea
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Neath Port Talbot Account So will remain
Old Swansea Trust Fund so remains in ABMU
Neath Port Talbot Account So will remain
Old Swansea Trust Fund so remains in ABMU
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Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Transfer
Transfer
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Transfer
Fund has been used as a health board wide fund and so needs to be split. Analysis of the source of donations shows a 92% share for Swansea and Neath Port Talbot and 8% share for POW. It is therefore agreed to split the fund on this basis.
Transfer
Fund has been used as a health board wide fund and so needs to be split. Analysis of the source of donations shows a 63% share for Swansea and Neath Port Talbot and 37% share for POW. It is therefore agreed to split the fund on this basis.
Fund has been used health board wide. Donations analysis is inconclusive so proposed split agreed with fund manager of 72:28 in accordance with the allocation split
Transfer
Transfer
Neath Port Talbot Account So will remain
Fund covers Neath and Bridgend. Donations analysis is inconclusive so agreed 50:50 split
Remain
Transfer
Fund set up in 2016 for Cymmer Health Centre So Remain
Service to Transfer to Cwm Taf
Transfer with YBN

Transfer
Transfer
Neath Port Talbot Account So will remain
Neath Port Talbot Account So will remain
Morriston League of Friends so remains
Singleton League of friends so remains
Old Swansea Trust Fund so remains in ABMU
Source of income is grants for schemes and sale of art at Morriston and Singleton as POW sales go into POW General Purpose Fund. Grants provided to date are for ongoing projects which cover areas of Bridgend and which will continue post 01.04.19 and be paid by ABMU from the grant until the scheme ends. No new grants will be bid for until 01.04.19 so nothing will transfer
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Transfers to Cwm Taf
Service Transfers to Cwm Taf
As site is transferring fund will transfer
Service Transfers to Cwm Taf
Fund is dormant and it has been requested that the balance transfer into Glanrhyd General Purpose which would then transfer to Cwm Taf. Fund history being reviewed to see source of donations - may need to be split across services.
Service Transfers to Cwm Taf
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Transfers to Cwm Taf
Service Remains with ABMU
Service Transfers to Cwm Taf
Service Transfers to Cwm Taf
Service Remains with ABMU
Old Swansea Trust Fund so remains in ABMU
Old Swansea Trust Fund so remains in ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU
Service Remains with ABMU

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INTERNAL AUDIT PROGRESS REPORT

Audit Committee - April 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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3. Delivery of the 2018/19 Internal Audit plan 1
4. Delivery of the 2019/20 Internal Audit plan 2

Appendix A:

Table 1: Status of 2018/19 assignments

Please note:

This audit progress report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, 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 Cwm Taf University Local Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

1.1. This progress report provides the Audit Committee (the 'committee') with the current position regarding the work undertaken by Internal Audit as at 21 March 2019.

1.2. The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the 2018/19, and any required updates.

2. Outcomes from completed audit reviews

2.1 Since the February meeting of the committee 9 assignments have been finalised. The finalised reports identified in the table below along with the allocated assurance rating are set out in the table below. The full versions of these reports are included in the committee's papers as separate items.

Assignments 2018/19	Assurance rating
Management of major capital	Limited
Patient experience	Reasonable
Welsh risk pool	Substantial
Directorate review – Primary Care compliance	Reasonable
Risk management	Reasonable
Service change plan	Reasonable
Core financial systems – cash management	Substantial
WHSSC - Risk management	Reasonable
WHSSC - Governance arrangements	Reasonable

3. Delivery of 2018/19 Internal Audit plan

3.1 The detail of the scheduling and current progress of the audit work is outlined in the assignment status schedule, which is included at Appendix A.

3.2 The schedule includes the timing of the audits. These dates may be subject to change as the audit work progresses, and any alterations will be communicated to the committee via future progress reports.

4. Delivery of 2019/20 Internal Audit plan

4.1 The plan for the 2019/20 programme of work is on the agenda for the committee.

Table 1: Status of 2018/19 assignments to be reported in April Audit Committee or later

Assignment	Days in plan	Status	Assurance	Timing	Notes
Management of major capital	25	Final	Limited	Q4	-
Patient experience	15	Final	Reasonable	Q3	-
Welsh risk pool	2	Final	Substantial	Q4	-
Directorate reviews – Primary Care - Compliance	15	Final	Reasonable	Q2	-
Risk management	10	Final	Reasonable	Q3	-
Service Change Plans	15	Final	Reasonable	Q3	-
Core financial systems – cash management	10	Final	Substantial	Q4	-
Cyber security	15	Draft	Limited	Q3	Draft report issued on 14.03.19
Water safety	15	Draft	Limited	Q3	Draft report issued on 14.03.19
Directorate reviews – Surgery - Management arrangements	30	WIP	-	Q3	Fieldwork on going
Directorate reviews – Surgery - Compliance	15	WIP	-	Q3	Fieldwork on going

Assignment	Days in plan	Status	Assurance	Timing	Notes
Commissioning	15	WIP	-	Q4	Fieldwork on going
Directorate reviews – Radiology - Management arrangements	30	WIP	-	Q4	Fieldwork on going
Directorate reviews – Radiology - Compliance	15	WIP	-	Q4	Fieldwork on going
Data quality review	15	WIP	-	Q4	Fieldwork on going
Health & Care standards	20	WIP	-	Q4	Fieldwork on going
GP Out Of Hours	20	-	-	Q4	Workforce element of OOH considered in primary care directorate review
WHSSC					
Risk management	10	Final	Reasonable	Q3	-
Governance arrangements	10	Final	Reasonable	Q4	-
EASC					
Governance and performance	15	WIP	-	Q2	Fieldwork on going

Assignment	Days in plan	Status	Assurance	Timing	Notes
Additional work					
Bridgend project	15	Ongoing	-	Q2	HoIA attending governance work stream
Review not taken forward in 2018/19					
Consultant job planning	15	-	-	Q3	Agreed at October 2018 Audit Committee that this review will be rescheduled for 2019/20

Reviews already reported

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Sustainability reporting	10	Final	Substantial	Q1	-
Annual Quality Statement	7	Final	Reasonable	Q1	-
JAG accreditation – Follow up	5	Final	Reasonable	Q1	-
General Data Protection Regulation (GDPR)	15	Final	Reasonable	Q1	-
Governance arrangements of Board committees	15	Final	Substantial	Q1	Focus on Primary Care committee

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Carbon reduction commitment	10	Final	Substantial	Q2	Mandatory review
Directorate reviews - Facilities – Compliance	15	Final	Reasonable	Q1	-
Performance management – follow up	5	Final	Reasonable	Q2	-
Retention of staff	15	Final	Limited	Q1	-
Directorate reviews: Facilities - Management arrangements	30	Final	-	Q1	Reported as 'draft' at the October 2018 committee
• Risk management and governance			Reasonable		
• Performance and planning			Reasonable		
• Workforce			Limited		
Raising concerns	15	Final	Limited	Q1	-
Well-being of Future Generations Act (Wales) 2015	10	Final	Reasonable	Q2	-
Continuing Health Care	15	Final	Reasonable	Q2	-
Medical equipment and devices	15	Final	Limited	Q2	-

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
IT systems	10	Final	Reasonable	Q2	-
Management of absence target	15	Final	Reasonable	Q3	-
Private & Oversea patients – Follow up	N/A	Final	Reasonable	-	-
Mandatory training	15	Draft	Reasonable	Q2	Draft report issued 18.01.19
Directorate reviews – Primary Care - Management arrangements	30	Final	-	Q2	-
Risk management and governance			Reasonable		
Performance and planning			Substantial		
Workforce			Reasonable		
WHSSC					
High cost drugs	15	Final	Reasonable	Q1	-
Review of network groups and advisory boards	10	Final	Reasonable	Q2	-

Appendix A

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
EASC					
EASC - Non-Emergency Patient Transport Service – Follow up of baseline position review	N/A	Final	N/A	-	Additional review requested by EASC

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Directorate reviews – summarised analysis

Audit Committee - April 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A: Findings in directorate reports

Appendix B: Findings relating to common themes

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1. Introduction

1.1. This paper sets out the common themes that we have identified in our directorate reviews within the Health Board. This paper captures information from our reports issued between 2016/17 and 2018/19. However, working with the Health Board, we have developed our approach to the directorate reviews in recent years so that more aspects of a directorate's operations are covered by our fieldwork.

1.2. We have reviewed the findings that have been reported to Audit Committee in our last nine directorate review reports. A table showing all of the summarised findings, and their priority rating is attached as Appendix A.

2. Summarised analysis of findings

2.1 Our directorate reviews cover four common areas of function within each directorate. The number of findings in relation to these areas are summarised in the table below:

Internal Audit area of focus	Total findings
Risk management and governance	28
Planning and performance	9
Workforce	46
Compliance with financial control procedures*	9
Total	**92**

**Two directorate reviews have included this area of focus, and have been reported to the Audit Committee at the time of this report.*

2.2 In the table below, we have summarised the top six common themes of the findings that we have identified in our directorate reports across the four areas of focus.

Top six common themes across the directorate reviews

Theme of finding	Total findings
Risk recording, reporting and monitoring	10
Annual leave	9
Flexi-time / Time off in lieu (ToIL)	8
Sickness/ absence management	8
PDR compliance	8
Terms of reference for directorate groups/committees	6

2.3 The detail in relation to the findings for the common theme areas is set out in Appendix B.

2.4 In the tables below, we have summarised the common themes of the findings that we have identified within our areas of focus that had four or more findings when we looked across our directorate reviews.

Common themes by area of focus (more than four findings)

Risk management and governance	
Theme of finding	**Total findings**
Risk recording, reporting and monitoring	10
Terms of reference for directorate groups/committees	6
Declarations of Interest	4

Planning and performance	
Theme of finding	**Total findings**
IMTP	5
Performance reporting	4

Workforce	
Theme of finding	**Total findings**
Annual leave	9
Flexi-time / Time off in lieu (ToIL)	8
Sickness/ absence management	8
PDR compliance	8

3. Conclusion

3.1 The finding summarised above show that the most common theme of findings related to the recording and reporting of risk within directorates.

However, the largest number of findings falls within the Internal Audit review objectives relating to workforce, such as annual leave, ToIL and sickness management.

3.2 We would encourage the Health Board to consider sharing this report across directorates so that the recurring themes identified in our reviews can be proactively considered by management to reduce the chance of related risks materialising.

Appendix A

Table 1: Findings per directorate report

Year	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
Directorate	**Primary care**	**Facilities**	**ACT**	**Medicines management**	**Pathology**	**Therapies**	**Acute medicine and A&E**	**C&YP**	**CAHMS**	**No**
	-	Risk records	Risk records	Risk records	-	-	Risk records	-	-	
	Risk register reporting	Risk reporting and monitoring	Risk reporting and monitoring	-	-	-	risk register monitoring	risk register monitoring	-	10
	Risk register monitoring	-	-	-	-	-	-	-	-	
	Terms of reference of CBM	-	Terms of reference of DIGBM and CBM	Terms of reference of directorate groups	-	-	Quality & Safety forum ToR	Governance of Q&S committee	Review of ToR for directorate governance groups	6
	-	-	-	-	Integrated governance meeting	-	Cancelled CBM	-	-	2
	-	-	-	-	Attendance at CBM	-	Directorate Integrated Governance meetings cancelled	-	-	2

Appendix A

Year	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
Directorate	**Primary care**	**Facilities**	**ACT**	**Medicines management**	**Pathology**	**Therapies**	**Acute medicine and A&E**	**C&YP**	**CAHMS**	**No**
	-	Comms. plan	-	-	-	-	-	-	-	1
	DoI	-	Declarations of interest	Declarations of interest	Declarations of interest	-	-	-	-	4
	-	-	Dissemination of alerts	-	-	-	-	-	-	1
	-	Up to date policies and procedures	Up to date policies and procedures	-	-	-	-	-	-	2
	-	IMTP monitoring	Tracking performance against IMTP	-	IMTP planning	-	IMTP development process	-	IMTP planning	5
	-	-	Tracking performance for Service Change plan and workforce	-	-	-	Introduction of Qlik Sense for performance reporting	Introduction of Qlik Sense for performance reporting	Introduction of Qlik Sense for performance reporting	4
	-	Annual leave process - porters	-	-	-	-	-	-	-	1

Appendix A

Year	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
Directorate	**Primary care**	**Facilities**	**ACT**	**Medicines management**	**Pathology**	**Therapies**	**Acute medicine and A&E**	**C&YP**	**CAHMS**	**No**
	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	Annual leave operations	9
	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	-	Flexi/ ToIL process	Flexi/ ToIL process	Flexi/ ToIL process	8
	-	-	-	-	-	-	Flexi leave - operational	-	-	1
	Absence management	Absence management	Absence management	Absence management	Absence management		Absence management	Absence management	Absence management	8
	PDR	PDR	PDR	PDR	PDR	-	PDR	PDR	PDR	8
	Mandatory training	Mandatory training	Mandatory training	-	-	-	-	-	-	3
	Rostering guidance	Rostering guidance	-	-	-	-	-	-	-	2
	-	Rostering doc.	-	-	-	-	-	-	-	1
	-	-	Future staffing plans	-	-	-	-	-	-	1

Appendix A

Year	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
Directorate	Primary care	Facilities	ACT	Medicines management	Pathology	Therapies	Acute medicine and A&E	C&YP	CAHMS	No
	-	-	Consultant job planning - sign off	-	-	-	-	-	-	1
	-	Rostering effectiveness	Rostering effectiveness	-	-	-	-	-	-	2
	-	Rostering review process	-	-	-	-	-	-	-	1
	-	Inventory of non-capital assets	Inventory of non-capital assets	-	-	-	-	-	-	2
	-	Budgetary control	asset register verification	-	-	-	-	-	-	2
	-	Cash & banking process design	Capital asset disposals	-	-	-	-	-	-	2
	-	Cash limits - cash held before banking	Stores - design	-	-	-	-	-	-	2

Appendix A

Year	2018/19	2018/19	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17	2016/17	
Directorate	**Primary care**	**Facilities**	**ACT**	**Medicines management**	**Pathology**	**Therapies**	**Acute medicine and A&E**	**C&YP**	**CAHMS**	**No**
	-	-	Additional staff payments	-	-	-	-	-	-	1
Total findings	**10**	**19**	**21**	**7**	**8**	**1**	**12**	**7**	**7**	

Note:

Colour coding represents the priority rating given to the original finding:

- Red – High priority finding
- Amber – Medium priority finding
- Green – Low priority finding

Findings relating to common themes

Below we set out the recommendations that relate to the common themes identified in the body of the report.

Findings	Total findings
Risk recording, reporting and monitoring • Directorates using more than one risk register and having a lack of consistency in the approach used. • Ensuring that directorate risk register is up to date. This includes logging the responsible officers and actions. • Proactive scrutiny and monitoring of risk through an appropriate group, such as a CBM. • Where appropriate, and in accordance with policy, need to keep risks logged on Datix up to date, ensuring actions taken are reflected on Datix. • Meaningful information on risk reports such as when the risk was first opened, and when it was last reviewed.	10
Annual leave • Ensuring that the correct carry forward balance of annual leave is used. • Monitoring of on-going annual leave balances by line managers. • If paper copies of annual leave are used, make sure they reconcile to electronic system (ESR). • Ensuring that annual leave is appropriately authorised.	9

Appendix B

<u>Flexi-time / Time off in lieu (ToIL)</u> • Local ToiL/flexi-time procedures are in place where this is applicable. • Recording and monitoring ToiL/ flexi-time by line manager.	8
<u>Sickness/ absence management</u> • Completion of sickness documentation in line with the All Wales policy. • Ensuring sickness episodes are recorded on ESR. • Undertaking and recording 'return to work' interviews.	8
<u>PDR compliance</u> • Recording appraisal information on ESR. • 'Sign-off' of PDR by staff member and line manager. • Ensuring that PDRs are undertaken with staff on an annual basis.	8
Terms of reference for directorate groups/committees • Where appropriate ensuring that directorate groups or committees have a clear terms of reference that sets out the expectations of the Health Board in relation to the group or committee.	6

Core Financial Systems – Cash Management

Internal Audit Report

Cwm Taf University Health Board 2018/19

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Follow up of previous recommendations
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-12
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Fieldwork commencement:	23 January 2019
Fieldwork completion:	18 March 2019
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Auditors:	Emma Samways, Sian George
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Distribution:	Huw Evans, Head of Finance (Financial Accounts, Capital & Systems) Mike Hopkins, Senior Finance Analyst
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.

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1. Introduction and Background

The audit review of an element of the Core Financial Systems was completed in line with the 2018/19 Internal Audit Plan. The review sought to provide Cwm Taf University Health Board (the 'UHB' or the 'Health Board') with assurance that there are effective processes in place to manage the risks associated with certain elements of the financial systems.

As part of the on-going cyclical review of the core financial systems, this year's review has focused on cash management.

The relevant lead for the review is the Director of Finance.

2. Scope and Objectives

The overall objective of this audit is to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's processes for cash management. The review will seek to provide assurance to the Health Board's Audit Committee that risks material the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- Procedure guidance is appropriate and up to date.
- A full year cash forecast is produced in a format consistent with the financial monitoring return.
- Regular updates to the cash forecast are made, and reviewed, with significant changes being appropriately reported.
- Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised.
- Transfers between accounts are appropriately authorised.

As part of our review, we also followed up on the recommendations made in our 2017/18 core financials audit review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Required payments cannot be made where sufficient cash is not drawn down.
- Surplus cash is drawn down unnecessarily and not in line with Welsh Government requirements.

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 Cash Management aspect of the Core financial systems is **Substantial** assurance.

RATING	INDICATOR	DEFINITION
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.

An up to date Financial Control Procedure is available for Cash Management and this is supported by desktop procedures for staff to utilise.

A full year cash forecast was produced in a format consistent with the Welsh Government financial monitoring return. It was produced at the start of the 2018/19 financial year in accordance with the stated procedures. Updates to the cash forecast are made on a monthly basis or more frequently if required with any changes discussed and reported appropriately. Forecasts are submitted in line with Welsh Government guidelines and the timetables set out at the start of each financial year.

Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts. Cash requests are submitted on a Welsh Government Financial Information System funding request form; and cash levels requested are appropriate and not excessive.

Transfers between accounts that we reviewed were appropriately requested, reviewed and authorised.

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 objective is described in the table below:

Assurance Summary					
1	Cash Management				✓

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

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as weaknesses in the system control/design for cash management.

Operation of System/Controls

The findings from the review have not highlighted any issues that are classified as weaknesses in the operation of the designed system/control for cash management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork.

Objective 1: Procedure guidance is appropriate and up to date.

We note the following areas of good practice:

- An up to date Financial Control Procedure is available for staff to reference during cash management processes.
- A desktop procedure has been created to give staff involved in the cash management process a guide to follow for carrying out tasks relating to cash management.

We did not identify any findings under this objective.

Objective 2: A full year forecast is produced in a format consistent with the financial monitoring return.

We note the following areas of good practice:

- The 2018/19 full year cash forecast was produced in a format consistent with the Welsh Government financial monitoring return.

We did not identify any findings under this objective.

Objective 3: Regular updates to the cash forecast are made, and reviewed, with significant changes being appropriately reported

We note the following area of good practice:

- Updates to the cash forecast are made and recorded appropriately with all changes discussed with the Head of Finance. Forecasts are submitted in line with the Welsh Government timetable for submissions.

We did not identify any findings under this objective.

Objective 4: Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised.

We note the following area of good practice:

- Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts. Cash requests that we reviewed were submitted on a correctly completed, signed and authorised Welsh Government Financial Information System funding request form; and cash levels requested are appropriate and not excessive.

We did not identify any findings under this objective.

Objective 5: Transfers between accounts are appropriately authorised

We note the following area of good practice:

- The Transfers between accounts that we reviewed were appropriately authorised. In addition, the requests for cash transfers between accounts, that we reviewed, were appropriately prepared, signed and authorised.

We did not identify any findings under this objective.

7. Summary of Recommendations

There were no recommendations arising from this review**.**

Original Finding 1 – Pursuit of outstanding debts (Operating effectiveness)	Risk
We analysed the value and number of aged debts listed on the month eight aged debt report. The analysis shows that there are outstanding Non NHS debts dating back as far as 2008/09, though it is acknowledged that a payment plan is in place for this debt and the outstanding balance is reducing. From 2008/09 to 2016/17 there are 291 outstanding debts totalling £1,657,764. Of these outstanding debts, 39 are £100 or less and a number do have instalment plans in place. Our testing of a sample of 20 outstanding debts and write offs, confirmed that debts are pursued in line with Financial Control Procedure. However, the continued pursuit of low value and / or historic debts where payment plans are not in place, may not be the most economical use of resources.	Inefficient use of resources
Original Recommendation	**Priority Level**
Where low value historical debts remain and no repayment plan is in place, management should decide if it is economical to continue to pursue these debts if all methods of collecting the money have been unsuccessful to date. Where applicable, these debts should be written off.	**Low**

Original Management Response	Responsible officer/deadline
Low value debts greater than 1 year old will be reviewed on an annual basis and written off if appropriate.	Senior Finance Officer (Debtors)/ Head of Finance March 2018

Current Position

We have been informed by Senior Finance Officer for debtors that:

- Those older invoices that the Health Board is still receiving money for will keep reducing month on month. There are not many of these that are still in repayment plans but as we are receiving money regularly then we would not 'write off' as the administration work involved is negligible.
- Invoices have been written off following a discussion with the Finance Manager based on the recommendation.
- A number of low value debts have been passed to CCI debt collection agency. Should no payment be made these debts will be written off.

We therefore consider this recommendation to have been implemented, and the recommendation closed.

Original Finding 2 – Personal loyalty card benefits (Control design)	Risk
During our testing of ten petty cash claims, we noted that for two expenses being reimbursed through petty cash, 'loyalty cards' had been used by the staff member making the purchase. The Financial Control Procedure does not offer guidance on staff who will personally benefit from using 'loyalty cards' when making purchases on behalf of the Health Board, (even if the monetary value added to the loyalty card is small).	Inappropriate expenditure and reputational damage if petty cash accounts are not properly managed
Original Recommendation	**Priority level**
Other Health Boards provide formal guidance to staff on the use of personal loyalty cards when making purchases to be reimbursed though petty cash, or other means. We consider this good practice and recommend that the Health Board consider developing similar guidance for staff to use as a point of reference. Staff using the petty cash system should be reminded that no personal gain should be made.	**Low**
Original Management Response	**Responsible Officer/ Deadline**
Reminders will be sent to all Petty Cash imprest holders requesting them to inform staff that personal loyalty cards should not be used when making petty cash purchases on behalf of Cwm Taf UHB.	Treasury Accountant March 2018

Current Position
In February 2018 an email was sent to all general office staff reminding them that the use of loyalty cards when making purchases to be claimed through petty cash should not be taking place. A follow up email was sent in October 2018 out when Health Board staff identified that loyalty cards were being used again. Given the action taken by the Health Board we consider this recommendation to have been implemented and the recommendation closed.

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 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 **high impact on residual risk** exposure until resolved.

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.

DRAFT

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Welsh Risk Pool

Internal Audit Report

2018/19

Cwm Taf University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-11
Report status:	Internal Audit Report
Fieldwork commencement:	04 February 2019
Fieldwork completion:	06 February 2019
Draft report issued:	15 February 2019
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Final report issued:	13 March 2019
Auditors:	Olubanke Ajayi Olaoye (Senior Internal Auditor) Emma Samways (Deputy Head of Internal Audit)
Executive sign off:	Angela Hopkins (Interim Director of Nursing, Midwifery and Patient Services)
Distribution:	Alison Davies (Assistant Director Quality Improvement and Clinical Governance) Ruth Friel – Head of Patient Experience Kellie Jenkins Forrester (Senior Manager for Investigations and Quality Improvement) Susie Egglestone- Clarke (Claims Team Manager)
Committee:	Audit Committee

ACKNOWLEDGEMENT
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1. Introduction and Background

Our review of Welsh Risk Pool concerns and compensation claims was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board').

The purpose of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard is to ensure that NHS bodies:

- Have an effective process for managing concerns raised by patients and staff.
- Have an effective process for managing legal claims for financial compensation.
- Ensure that there is good organisational learning from all events.

Area for Assessment 23 of the standard requires Internal Audit to review the accuracy of a sample of compensation claims for reimbursement, made on Welsh Risk Pool Services.

The relevant lead for the review is the Interim Director of Nursing, Midwifery and Patient Care.

2. Scope and Objectives

The objective of this audit was to provide assurance to the Health Board's Audit Committee over the adequacy of the systems and controls in place for the management of claims reimbursement, and to test the accuracy of the claims made.

The purpose of the review was to provide assurance to the Audit Committee that the claims reimbursement process is in compliance with the Welsh Risk Pool Standard.

The objectives of the review were to provide assurance that:

- Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Corporate Services Manager.
- Appendix S checklists are completed by the corporate services manager and signed by the Chief Executive and Director of Nursing, Midwifery and Patient Services; and forwarded to the Welsh Risk Pool.
- Claims submitted are accurately entered onto the Datix risk management database.

3. Associated Risks

The potential risk considered in this review is that claim costs reimbursed from the Welsh Risk Pool are inaccurately recorded, and not appropriately authorised by the Health Board's senior management.

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 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. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Welsh Risk Pool claims is substantial assurance**.**

RATING	INDICATOR	DEFINITION
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.

For the sample of ten reimbursed claims that we reviewed we confirmed that the Health Board's claims reimbursement process was undertaken in compliance with Assessment Area 23 of the Welsh Risk Pool Concerns and Compensation Claims Management Standard, and the Health Board's Organisational Claims Handling Policy and Procedure.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate and accurate completion and authorisation of Appendix U cost schedules.				✓
2	Appendix S checklists are appropriately completed and authorised.				✓
3	Claims submitted are accurately entered onto the Datix risk management database				✓

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

Design of Systems/Controls

We did not identify any findings from the review that are classified as weaknesses in the system control/design in respect of WRP claims reimbursement.

Operation of System/Controls

Our findings from the review have highlighted one issue that is classified as a weakness in the operation of the control for WRP claims reimbursement.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Claims Manager

We note the following area of good practice:

- For the ten claims that we reviewed, we found that the Appendix U Cost schedules had been accurately completed and authorised by the Health Board's Chief Executive.

We did not identify any findings under this objective.

Objective 2: Appendix S Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool

We note the following area of good practice:

- We were able to evidence confirmation of the approval and payment of the reimbursement to the Health Board by the Welsh Risk Pool Committee.

We identified the following finding:

- Three of the ten claims that we tested had one part of Appendix S signed by someone other than the named person pre-printed on the form.

Objective 3: All claims submitted are accurately entered onto the Datix Risk Management Database

We note the following area of good practice:

- For the ten claims that we reviewed we found that all claims were accurately recorded on the Datix risk management database.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and 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	**0**	**0**	**1**	**1**

Finding 1 – Completion of checklist form (Operating effectiveness)	Risk
A number of forms require completion as part of the Welsh Risk Pool claims process. We note that this year Appendix S has been changed and its focus is now about learning from the events that led to the WRP claim. The learning from events form requires designated members of staff to sign off specific sections. The declaration part of the form (section 8) is pre-printed with the name and position of the person required to sign, namely the Senior Manager for Investigations and Quality Improvement. Our review of ten (25%) of reimbursed and closed claims found that in three instances the declaration made in section 8 of the form had been signed by the Claims Team Manager, but the pre-printed name and job title had not been amended and still stated 'Senior Manager for Investigations and Quality Improvement'.	Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.
Recommendation	**Priority level**
Management should remind staff that when the signing of documents are carried out on behalf of another member of staff, the pre-printed names and job titles on the form should be amended to record who is actually signing the form.	**Low**

Management Response	Responsible Officer/ Deadline
The pre-printed names and job titles on the Appendix S form are now amended to record who is actually signing the form, this is quality assured by the Claims Team Manager.	Claims Team Manager, completed February 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 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 **high impact on residual risk** exposure until resolved.

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.

Service Change Plan –

Early Cancer Diagnosis Programme

Internal Audit Report

2018/19

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU-1819-10
Report status:	Internal Audit Report
Fieldwork commencement:	7 January 2019
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Draft report issued:	28 February 2019 & 11 March 2019
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Auditors:	Emma Samways (Deputy Head of Internal Audit) Kimberley Rowe (Principal Internal Auditor)
Executive sign off:	Ruth Treharne, Deputy Chief Executive & Director of Planning and Performance John Palmer, Chief Operating Officer
Distribution:	Chris Moss, Head of Planning Annie Hughes, Planning 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 Cwm Taf 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

A review of the Health Board's arrangements in relation to service change plans has been carried out in line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board').

The Health Board's 2018/21 IMTP makes reference to the service changes needed within the Health Board over the span of the IMTP. These are grouped around five themes: Wellbeing; Integrated Community Care; Acute Care; Tertiary Care; and Care Closer to Home. Where relevant, strategic links are made between significant service change plans and capital investment plans. Annex A3 of the IMTP provides detailed information of the service change plans falling under each of the five themes.

Within the Acute Care theme a number of programmes are identified, one being Cancer Services. In 2016, the Welsh Government published a refreshed national cancer delivery plan, which set out a number of national priorities. During 2017/18, the Health Board reviewed its cancer work programme in the context of the refreshed national delivery plan. One of the key priorities included in the Health Board's cancer work programme is in relation to Early Cancer Diagnosis programme (the 'programme' or the ECD), and this programme of work forms one of the service change plans outlined in the IMTP Annex A3. This has been the focus of this review.

The programme comprises of three work streams, namely the Rapid Diagnostic Clinic (RCD), the Cancer Inequalities Steering Group and the Urgent Suspected Cancer (USC) Pathway Improvement Group. The programme reports into the Cancer Implementation Group (CIG). The audit review has focussed on the work streams, and primarily the Rapid Diagnostic Clinic and USC Pathway Improvement as the Cancer Inequalities work stream is in its infancy.

The relevant Executive leads for the review are the Chief Operating Officer and the Deputy Chief Executive/ Director of Planning and Performance.

2. Scope and Objectives

With a specific focus on the Early Cancer Diagnosis programme, the overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's management of processes for service change plans. The review sought to provide assurance to the Health Board's Audit Committee that risks material to achieving the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- There is a clear alignment between the objectives of the programme and the IMTP and other Health Board strategies.
- A defined outcome and Specific, Measurable, Achievable, Realistic and Timely (SMART) targets for the programme have been set and appropriately agreed.
- There is appropriate ownership of the programme and suitable governance arrangements are in place.
- The risks associated with the programme are documented and appropriately regularly reviewed.
- Appropriate resources, such as finance, planning and workforce have been allocated to the programme.
- Reporting mechanisms are in place to monitor the progress of the programme against defined targets and outcomes.
- Regular reviews of the programme take place to learn from activities to date and to influence the future direction of the programme, and roll out on a wider scale across Wales.

3. Associated Risks

The potential risks considered in the review were as follows:

- Resources are not well used as a result of work being undertaken that is not in line with objectives of the Health Board.
- The programme fails to meet its desired targets and outcomes where there are insufficient resources.
- Service change outcomes are not met as corrective action is not taken where issues are identified or performance targets are not being met.

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 Early Cancer Diagnosis programme service change plan is Reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

There is a clear alignment between the objectives of the Early Cancer Diagnosis Programme and those committed to, and agreed within, the IMTP to progress the National Cancer Delivery Plan.

To ensure that the objectives of the programme are met defined outcomes should be in place. We found that whilst these outcomes are in place for the programme's work streams that we reviewed, further work is required to develop targets that can be used to measure the achievement of the outcomes.

The established cancer services structure within the Health Board has provided good foundations and created governance arrangements, and reporting mechanisms for the programme and its work streams. However, there is work to be done on how this structure manages and documents both risks and resources for both the current and future service.

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	Alignment of objectives				✓
2	SMART targets		✓		
3	Ownership and governance arrangements				✓
4	Risk documentation		✓		
5	Allocated resources			✓	
6	Reporting mechanisms				✓
7	Reviews and Roll Out				✓

** 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 a weakness in the system control/design for cancer services - service change plan.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for cancer services - service change plan.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: There is a clear alignment between the objectives of the programme and the IMTP and other Health Board strategies.

We note the following area of good practice:

- We compared the objectives documented within the relevant groups' terms of reference, the work streams' quarterly highlight reports and other relevant documentation, to those objectives identified in the IMTP to support the National Cancer Delivery plan. There was clear alignment of the programme objectives to those set out in the IMTP.

We did not identify any findings under this objective.

Objective 2: A defined outcome and Specific, Measurable, Achievable, Relevant and Timely (SMART) targets for the programme have been set and appropriately agreed.

We note the following area of good practice:

- The programme's outcomes that have been developed are relevant to the work streams and are linked to the IMTP.

We identified the following finding:

- Whilst the outcomes that have been set are specific, they do not indicate a baseline or specify the comparative period, for example, the rolling 12 months, quarter on quarter, or specify the percentage reduction or increase to be achieved.

  One outcome states an improved patient experience, but does not define patient experience, which can be interpreted in a number of ways.
- Whilst all the outcomes are measurable, we note that the performance indicators set for the Rapid Diagnostic Clinic mirror those in the Welsh Cancer Network (WCN) returns, but do not specifically measure the outcomes listed for the Health Board's RDC work stream.
- The outcomes for the Rapid Diagnostic Clinic have been categorised as short or long term, however these terms have not been given a definite time period. Only one of the outcomes for the USC Pathway Improvement work stream specifies the time period, the remaining three outcomes do not have time bound constraints.
- There are no agreed outcomes for the Reducing Cancer Inequalities and Raising Public Awareness work stream, due to the infancy of this work stream.

Objective 3: There is appropriate ownership of the programme and suitable governance arrangements are in place.

We note the following areas of good practice:

- There is a strong, documented, governance structure in place for cancer services within the Health Board.
- The cancer programmes are overseen by the Cancer Implementation Group (CIG). There is a terms of reference, and the group is chaired by the Medical Director, who holds the Executive portfolio for cancer services and is deputised by the Clinical Lead for Cancer Services. The group meets quarterly and reports directly into the Executive Board via an annual report. The CIG monitors the programme's progress through the Early Cancer Diagnosis Programme Group.
- The Early Cancer Diagnosis Programme Group is the main working group with oversight of the implementation of the programme. The group is chaired by the Chief Operating Officer so has good links with the Executive Board, and has a Vice Chair who has involvement with the Wales Cancer Network. The Early Cancer Diagnosis programme oversees the three work streams, each of which has their own working group that provides regular report updates to the Early Cancer Diagnosis Programme Group.

We did not identify any findings under this objective.

Objective 4: The risks associated with the programme are documented and appropriately regularly reviewed.

We identified the following finding:

- We could not evidence the recording of risk from any of the three work streams that we reviewed. Risk is not included on the highlight reports to the Early Cancer Diagnosis programme board and therefore do not appear to be escalated to the CIG for potential inclusion on the Health Board's risk register.

  However, the quarterly Rapid Diagnostic Clinic progress report contains a list of key risks to the clinic, but these have been given an 'amber' status and are being managed by mitigated actions so none have been escalated to the CIG. This report also highlights 'areas for concern' and has noted 'securing funding for continuation of the service post March 2019', however this is not included in the key risks as a prevailing risk for the clinic.

Objective 5: Appropriate resources, such as finance, planning and workforce have been allocated to the programme

We note the following areas of good practice:

- There is widespread involvement of workforce in the work streams by way of membership of the groups and programme Board with good

connections to the Executive Board.

- The University of Bath has been jointly commissioned by the Health Board and the Wales Cancer Network to undertake a project to produce a toolkit that is transferrable to assess any pathway.

We identified the following finding:

- The Wales Cancer Network allocated funding to the Rapid Diagnostic Clinic work stream for 2017/18, 2018/19 and a reduced amount in 2019/20. Due to this being external funding, spend is monitored, with the majority of spend being on providing the workforce for the clinic. The current monitoring only concentrates on the current financial year and does not track previous spend or forecast beyond March 2019. In order to roll out or expand this service, accurate financial records will need to be available to enable projections.

  At the time of our fieldwork, the Rapid Diagnostic Clinic were waiting for the outcome of their bid for funding from the Transformation Fund in order to secure funding for the continuation of the service post March 2019. However we were later informed that this bid had been removed from the Transformation Fund bid and will be funded via Radiology. Without this funding, there is a risk to the future service delivery, although this was not formally recorded as a risk.

  There is no specific monitoring of spend for the other individual work streams.

Objective 6: Reporting mechanisms are in place to monitor the progress of the programme against defined targets and outcomes.

We note the following areas of good practice:

- The reporting mechanisms within the Health Board form part of the governance structure within cancer services.
- We note that the Rapid Diagnostic Clinic is closely monitored through the Welsh Cancer Network and is required to submit monthly metrics to monitor performance.

We did not identify any findings under this objective.

Objective 7: Regular reviews of the programme take place to learn from activities to date and to influence the future direction of the programme, and roll out on a wider scale across Wales.

We note the following area of good practice:

- The Health Board have been developing a framework to support the evaluation of innovative ways of organising the diagnostics services for cancer patients within the Health Board. The report, developed by the University of Bath, was been rolled out internally in February 2019.

We did not identify any findings under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**2**	**1**	**1**	**4**

Finding 1 - SMART targets (Operating effectiveness)	Risk
The Early Cancer Diagnosis programme is made up of three work streams, the Rapid Diagnostic Clinic, USC Pathway Improvement group, and the Inequalities in Cancer Group. The latter of these work streams is in its infancy and as yet there are no agreed outcomes for its work. Our review has therefore focused on the outcomes and targets of the other two work streams. For the individual work streams that we tested, we reviewed the highlight reports that are reported to the programme group and provide a summary of recent activity within individual work streams, and assessed the outcomes recorded on them to ensure that the targets reported were SMART. We note that: • Whilst work stream outcomes have been set, there were no specific targets to support them. For example, they did not indicate a baseline or specify a comparative period such as a 12-month rolling period, or quarter on quarter, nor do they specify the reduction or increase they plan to achieve. In addition, one outcome for the RDC work stream is for an improved patient experience, but does not define 'patient experience', which can be interpreted in a number of ways. • Whilst the work stream outcomes were measurable, we note that the performance indicators included for the Rapid Diagnostic Clinic (RDC) work stream did not specifically measure the outcomes that are listed.	Resources are not well used as a result of work being undertaken that is not in line with objectives of the Health Board.

• The outcomes for the RDC work stream have been categorised as either 'short' or 'long' term, however these terms have not been given a definitive time period. • Only one of the outcomes for the USC Pathway Improvement work stream specifies the time by which the outcome should be achieved, the remaining three outcomes did not have time bound constraints.	
Recommendation	**Priority level**
The work stream groups should ensure that the targets set to meet their outcomes use the SMART principles to help ensure that the targets are appropriate and focused.	**High**
Management Response	**Responsible Officer/ Deadline**
The Early Cancer Diagnosis Programme Board (ECDPB) will review the outcomes aligned to each work stream in order to determine measurable targets for performance monitoring. The ECDPB notes that the allocation of time-specific performance metrics for the RDC work stream may be more challenging due to the uniqueness of the pathway, however this will be reviewed and metrics put in place where feasible. We also note that national optimal USC pathways are currently being agreed at a national level as part of Single Cancer Pathway implementation. These will include optimal pathway timeframes which will act as targets for delivery.	Planning Manager (Scheduled Care) Head of Planning (Scheduled Care) June 2019

A service evaluation of the RDC is currently being undertaken in partnership with Bath University. This evaluation includes a full assessment of the short and long term outcomes agreed at the outset of service development and implementation. The evaluation will be complete by June 2019 and reviewed by the ECDPB to inform future service planning and delivery. **Action:** • Review outcomes for each work stream and set measurable performance targets with definitive time periods. Month on month progress to monitored at each meeting of the ECDPB. • Utilise the forthcoming evaluation of the Rapid Diagnostic Clinic to inform future service planning and set measurable progress milestones for future service delivery.	

Finding 2 - Risk management (Control design)	Risk
Our review has identified that risk reporting from the three work streams is not included on the highlight reports to the Early Cancer Diagnosis Programme Board, and therefore is an area that appears to have been overlooked. Risks are not being recognised, reported and potentially escalated for inclusion in the Health Board's risk register. However, we note that the RDC work stream quarterly progress report contains a list of key risks to the clinic. These have been given an 'amber' status and are being managed by mitigated actions, so none have been escalated to the CIG. This report also highlights 'areas for concern' and has noted 'securing funding for continuation of the service post March 2019', which is not included in the key risks, yet would be a prevailing risk for the clinic. In our recent corporate review of risk management we recommended that risks relating cancer services are monitored through the Cancer Strategy and Steering Group (CSSG), and escalated to the Cancer Implementation Group (CIG). Our recent follow up work in this area established that a flow chart outlining the process to be followed for capturing and monitoring risks has been developed, but we have not been able to confirm if this flowchart has been implemented.	Service change outcomes are not met as corrective action is not take where issues are identified or performance targets are not being met.

Recommendation	Priority level
The Early Cancer Diagnosis (ECD) Programme Board should produce a risk register to capture risks, measure them and document the mitigating actions for each of the programme work streams. The work streams highlight reports should include details of the risks specific to that area in order to allow monitoring and consideration of escalation to the ECD Programme Board and CIG where relevant.	**High**
Management Response	**Responsible Officer/ Deadline**
Any risks discussed at ECDPB are escalated to the Cancer Implementation Group via a work stream highlight report, however we acknowledge that risks should be formally captured on a risk register for the purposes of transparency. We note that any risks raised with the ECDPB relate to funding and operational matters as opposed to clinical risk. Any risk in relation to a clinical incident / patient safety is reviewed and managed at clinical directorate level. **Action:** Develop a formal risk register for the ECDPB, to be reviewed and discussed as each meeting. Where relevant, any significant risks to be formally escalated to the Cancer Implementation Group and/or Executive Board.	Planning Manager (Scheduled Care) Head of Planning (Scheduled Care) May 2019

Finding 3 - Financial resource and monitoring (Operating effectiveness)	Risk
The work streams for the early diagnosis cancer programme operate within the Health Board's current directorates. While financial monitoring is undertaken for the Rapid Diagnostic Clinic (RDC) work stream, as it is externally funded by the Wales Cancer Network, we note that as there is no external funding for the other work streams no formal financial monitoring takes place. Whilst we acknowledge that the main costs relate to staff, financial monitoring arrangements should be in place in order to identify the cost implications of each of the work streams. However, due to the nature of the current activity, with no additional resource outside of current establishments being used, we do not consider this to be a high risk. We note that for the RDC work stream the Wales Cancer Network has allocated funding to the for the following periods: • 2017/18 - £200k • 2018/19 - £200k • 2019/20 - £100k The forecast report as at December 2018 shows that the majority of finance resources in the current year is for providing the workforce for the clinic. Monitoring concentrates on the current financial year and does not track previous spend or forecast beyond March 2019. The forecast sheet also notes a sum of £100k bought forward from previous years, but this is a rounded figure and not	The programme fails to meet its desired targets and outcomes where there are insufficient resources

the exact amount. In order to roll out or expand this service, accurate financial records will need to be available to enable projections. We understand that the RDC work stream is waiting on the outcome of their bid for funding from the Transformation Fund in order to secure funding for the continuation of the service post March 2019. Without this funding there is a risk to the future delivery of the service.* *After the audit fieldwork, we were advised that the Early Cancer Diagnosis element of the Transformation Fund bid was removed and future costs would be included in the Radiology Budget in the IMTP.	
Recommendation	**Priority level**
The work stream groups should ensure they are accurately monitoring spend against allocated funding. This should include analysis over the programme life in order to aid future forecasting.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The spend for the RDC against allocated funding is robustly monitored by Finance and Planning colleagues working with the Radiology Directorate (as host Directorate for the RDC budget). A budget update is also reported to the Wales Cancer Network. The £100k funding allocated for 2018/19 is the amount allocated through the IMTP process.	Early Cancer work stream Leads (Deb Lewis/Gareth Davies/Anthony Gibson/Sara Thomas) April/May 2019 - Ongoing

Financial projections for the work stream are based on potential future staffing models. Scoping work has already been undertaken to develop proposals for future service models. **Action** • The process in place for robust and accurate monitoring of RDC expenditure will continue and this approach will be replicated across work streams to monitor future spend against budget allocations. • Where possible, the ECDPB will monitor the financial impact (spend and/or associated costs saving) of USC pathway changes implemented as part of the early cancer programme.	

Finding 4 – Reporting (Operating effectiveness)	Risk
Our review of the monitoring return for the RDC work stream to the Welsh Cancer Network identified that it does not include comparative data from previous submissions or from other pilot schemes, therefore it is difficult to draw conclusions on performance. Whilst we acknowledge that these are the metrics required by the Welsh Cancer Network, and the Health Board are complying with their reporting obligations, we would consider it beneficial if the comparative data was available. This may help with internal monitoring of the work stream within the Health Board.	The programme fails to meet its desired targets and outcomes where there are insufficient resources; and Service change outcomes are not met as corrective action is not taken where issues are identified or performance targets are not being met.
Recommendation	**Priority level**
The WCN returns should be collated to build trends for the programme, but also to be used as comparative data to other Health Board schemes.	**Low**
Management Response	**Responsible Officer/ Deadline**
Planning and Performance colleagues have worked closely and undertaken an internal trend analysis for many of the metrics submitted to the WCN and which have been reported to the RDC operation group and ECDPB. The service evaluation currently being undertaken by Bath University will include a comprehensive analysis of clinic activity as well as a comparative assessment of	Planning Manager (Scheduled Care) Head of Planning (Scheduled Care)

the service with similar RDC models operating in ABMU and through the ACE Wave 2 Programme in England, this comprising 5 projects piloting Multidisciplinary Diagnostic Centre (MDC) based pathways. **Action:** • Data trends to be monitored through the ECDPB on a bi-monthly basis.	July 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 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 **high impact on residual risk** exposure until resolved.

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.

Patient Experience

Internal Audit Report

2018/19

Cwm Taf University Health Board

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Auditors:	Lucy Jugessur, Principal Internal Auditor Emma Samways, Deputy Head of Internal Audit
Executive sign off:	Professor Angela Hopkins, Director of Nursing, Midwifery & Patient Services (Interim)
Distribution:	Alison Davies, Assistant Director of Quality & Patient Experience Ruth Friel, Head of Patient Experience
Committee:	Audit Committee

ACKNOWLEDGEMENT
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1. Introduction and Background

In line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board') a review of the processes around the arrangements for gathering patient experience information was carried out. The key focus of the review was to consider if data is being routinely collected and used appropriately and effectively to inform service improvement in accordance with the objectives of the Health Board.

Patient experience is recognised as one of the central elements of quality in the NHS. For example, the Parliamentary review of Health and Social care in Wales (2018) and the Wales Assuring Service User Framework (2015) has confirmed listening to service users and acting upon the feedback at the heart of its plans for NHS Wales. There is a commitment that patients will be listened to and that feedback on patient and user experience will be obtained, published and acted on by NHS Wales Health boards and trusts.

The Health Board has established a number of means by which to receive feedback including real time surveys, retrospective surveys and patient stories.

The relevant lead for the review is the Interim Director of Nursing, Midwifery and Patient Services.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's management of processes in relation to patient experience. The review sought to provide assurance to the Health Board's Audit Committee that risks material the system's objectives were managed appropriately.

The areas that the review sought to provide assurance on were:

- The Health Board has a patient experience strategy in place detailing its commitment to listening to, and learning from, patient's experiences, and its approach to ensuring co-ordination of patient experience related activity.
- There are established and appropriate mechanisms and resources in place for the collection of patient experience feedback that covers all relevant areas within the Health Board.
- The Health Board triangulates specific patient experience information gathered with other types of data such as complaints, concerns, incidents and findings of service reviews.
- Patient experience reports, which highlight trends and themes, are reported regularly to the Board and other relevant forums.
- The Health Board takes timely appropriate action on both positive and negative patient experience feedback that it receives.

During the audit we reviewed the corporate process and processes in place within the Therapies and Acute Directorates.

3. Associated Risks

The risks considered in the review were as follows:

- Insufficient progress in obtaining feedback from patients resulting in a lack of learning.
- Patient experience reports are not being produced and acted upon within the Health Board.
- Inaccuracies or inconsistencies with patient experience data being collected, resulting in service improvement decisions being based on misleading information.
- Reputational damage where action is not taken.

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 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. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls for the Patient Experience is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

The Welsh Government has identified patient experience as fundamental within the NHS and that there should be framework in place to improve the service user experience and obtain lessons learnt from it. There was a

Patient Experience Plan 2014-17 which was developed to detail the Health Board's priorities in achieving excellent patient experience and to inform improvements. The Plan is aligned to Welsh Government methods as it uses the four quadrant framework of patient feedback methods of Real Time, Retrospective, Proactive/ Reactive, and Balancing. This original plan has been superseded by the updated Patient Experience Plan 2018-2021 that builds on the previous plan, though does not have the same level of detail as the original plan in relation to the actions that will be taken to achieve the plans ambitions.

During the review, we saw evidence of patient experience data being collected from a number of sources and differing approaches used to ensure varying patient groups are catered for, for example social media or paper based questionnaires. There is the risk that there is not full coverage in obtaining feedback from patients within all services and locations and that some areas might not be captured at all. However it is acknowledged that there is a resource implication associated with wider coverage.

The Patient Experience Team triangulates patient experience information with other types of data such as patient safety data, coroner's reports and claims. This information is reported to directorates to discuss within their meetings. We note that within the directorates reviewed, there are different forums where patient experience data is reported and there does not appear to be any consistency in reporting.

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	Patient Experience Strategy				✓
2	Collection of patient experience feedback			✓	
3	Triangulates patient experience information				✓
4	Patient experience reports are reported to the Board and other relevant forums			✓	
5	Health Board takes timely appropriate action				✓

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

Design of Systems/Controls

We did not identify any findings from the review that are classified as weaknesses in the system control/design for patient experience.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for patient experience.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Health Board has a patient experience strategy in place detailing its commitment to listening to, and learning from, patient's experiences, and its approach to ensuring co-ordination of patient experience related activity.

We note the following areas of good practice:

- The Health Board has had a Patient Experience Plan in place for a number of years. The 2014-17 plan was developed to detail the Health Board's priorities in achieving excellent patient experience and to inform improvements. The plan was based around Welsh Government guidance, using a four quadrant framework of patient feedback methods: Real Time; Proactive / Reactive; Retrospective; and Balancing.
- The 2018-2021 Patient Experience Plan was approved by the Board in July 2018 and builds on the framework used in the previous plan. It sets out the current practices in place to gain patient experience and uses the feedback gathered, aligned to the four quadrants of the Welsh Government Assurance for Service User Experience Framework. Within these areas there were examples of how patient experience was being acquired.

We identified the following finding:

- The 2018- 21 Patient Experience Plan contains a list of ambitions and actions. Previous versions of the plan has seen a more detailed action plan to support the achievement of the actions, including timeframes for achievement, responsible officers or groups and how the outcome will be measured. The current version of the plan does not provide this level of detail.

Objective 2: There are established and appropriate mechanisms and resources in place for the collection of patient experience feedback that covers all relevant areas within the Health Board.

We note the following areas of good practice:

- The Health Board use a number of methods to collect patient experience feedback including, patient surveys, 'Have your Say' cards, and social media.
- The Health Board has been involved in a National Patient Experience Collaborative with 13 other NHS Trusts across England and Northern Ireland, with the Patients Advice and Liaison Service (PALS) Officers undertaking real time surveys across eight wards. Patients on the wards

at that time were surveyed to provide a baseline with follow up visits taking place twice a month. The PALS Officers would provide the ward manager with the feedback the same day it is collected and this had a positive impact as issues were dealt with immediately. Real time survey work has now commenced in mental health and is due to commence in maternity services.

- We met with the Therapies Directorate who carry out patient experience feedback including Patient Reported Experience Measures (PREMs) to ascertain the patient's experience of care that they have received. 'Have your Say' boxes are held within the Outpatients area of Physiotherapy and patients are able to comment on their experience with Physiotherapy.
- We met with the Acute Directorate and they undertake monthly surveys. In addition, a process has been agreed whereby HSDU and Critical Care patients will be contacted after discharge to provide feedback about their time in these wards.

We identified the following findings in relation to this objective:

- Given the resource implications the real time surveys are only able to be undertaken within specific areas at a time. In general, there is a risk that not all services and locations are being covered when obtaining patient experience feedback and that not all groups are being included.
- The corporate team are not always made aware by directorates when they are undertaking their own patient experience data gathering work and as such the results may not be shared corporately.

Objective 3: The Health Board triangulates specific patient experience information gathered with other types of data such as complaints, concerns, incidents and findings of service reviews.

We note the following areas of good practice:

- The Patient Experience Team triangulates patient experience information with other data including patient safety data, coroner reports and claims. This information is reported to directorates to discuss within their meetings.
- The Health Board has developed a patient safety app to extrapolate service user experience information out of the risk management system enabling complaints, compliments, patient safety incidents and claims to be reviewed.
- There is a corporate weekly Putting Things Right panel which reviews complaints and patient safety incidents.

We did not identify any findings under this objective.

Objective 4: Patient experience reports, which highlight trends and themes, are reported regularly to the Board and other relevant forums.

We note the following areas of good practice:

- Patient Experience reports were taken to the Board in July and September 2018. These detail the current patient experience activities undertaken within the Health Board. The most recent report records the different sources of patient experience data, common themes and the further progress required. The report also provided detail on the top three themes for informal concerns and 'Have Your Say' top three subjects and the main issues and outcomes.
- Directorate Patient Safety Managers are aligned to the directorates and support directorates in the management of patient safety incidents. On a quarterly basis they provide reports for the Directorate Clinical Governance or Clinical Business Meetings which includes data on patient experience. However, it is the responsibility of the directorates to manage Patient Experience as they have access to the Qlik system whereby they can run off reports on patient experience to keep up to date with what has been reported by the patients.
- There is a weekly report for the patient safety executive meeting which includes the Medical Director, Director of Nursing and Head of Patient Experience, which includes patient experience information. Patient Experience is reported into the Quality Committee.
- We met with the Therapies Directorate and there are quarterly Therapies Integrated Governance meetings held chaired by the Therapies Clinical Quality Manager and within this meeting a report on informal concerns and compliments is taken by the Patient Advice & Liaison Officer. There is also a report of concerns, including claims, inquests, complaints, patient experience and patient safety incidents taken to the meetings.
- Within the Acute Directorate there are a number of meetings held whereby patient experience is discussed including Band 7 Forums and patient stories are provided in this meeting. There are department meetings held and Patient Experience and Quality Summary Reports are provided for the Directorate which details any patient safety incidents, incident trends, top incident issues, actions, inquests and complaint trends.

We identified the following finding:

- The monitoring of patient experience is inconsistent within the directorates. Some have Clinical Governance Meetings and report there, while others add patient experience to the Clinical Business Meetings.

Objective 5: The Health Board takes timely appropriate action on both positive and negative patient experience feedback that it receives.

We note the following areas of good practice:

- All positive and negative feedback is presented through the patient experience Qlik Sense app. Going forward all heads of service and service managers will be given access to the app and will be able to view their performance with regards to patient experience in real time.
- The Health Board was involved in the National Patient Experience Collaborative and as part of the project they reviewed eight Medical and Surgical wards. The ward managers, front line staff, and service users were provided with the feedback from the survey results on the same day.
- Compliments that have been received are shared on a weekly basis with the communications team and displayed on TV screens across outpatient areas.
- Have Your Say cards are across outpatient sites to capture retrospective service user experience and the information is collated shared with the public in the form of 'You said, We did' posters.
- The IMTP of the Therapies Directorate detailed issues that had been identified within the Directorate and how these had been resolved.
- The Health Board has been following up patients in HSDU and Critical Care that were discharged six months ago to reflect on the patient's time in these units and any issues are fed back.

We did not identify any findings under this objective.

7. Summary of Recommendations

The audit findings and 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	**0**	**3**	**1**	**4**

Finding 1 - Collection of patient experience feedback (Operating effectiveness)	Risk
We identified that there are a number of methods in place for collecting patient experience data. Some data is collected corporately through real time surveys, patient stories and patient surveys, and there is patient experience data gathering, to varying extents, being undertaken by individual directorates. However, we are unclear if the corporate team are always made aware of the work in directorates, and if they are informed of the outcomes. Whilst the corporate team are proactive in trying to establish the work undertaken by directorates, there have been cases when directorates have not sought the advice and expertise of the corporate team. Furthermore without directorates sharing the information they gather, the corporate team will not be able to triangulate it to other data relating to the directorate. In 2017, the PALS officers targeted specific wards within Surgery and Medicine to undertake real-time surveys and provide immediate feedback. The visits and re-visits took place over a number of months and it has been reported that these had a positive impact on improving patient experience on those wards. Similar work has now commenced in mental health services and will shortly commence in maternity services. However, there is the risk that there is not full or consistent coverage in obtaining feedback from patients within all services and locations, and that some areas where there are known concerns or seldom heard groups may not be having patient experience data captured at all. However, we acknowledge that there is a resource implication in being able to gather data	Insufficient progress in obtaining feedback from patients resulting in a lack of learning.

from all areas of the Health Board. It is therefore essential that the resource that is available, is used effectively.	
Recommendation	**Priority level**
Directorates should be reminded that the corporate patient experience team can provide them with advice and guidance when gathering their own patient experience data. The corporate team should be made fully aware of work that is being undertaken within directorates to gather data and should be provided with the outcome of information gathered. Given the resource implication of not being able to undertake real time surveys in all areas of the Health Board, a targeted programme of areas to visit should be developed, focusing on known 'hot-spots'.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Health Care Monitoring system is in place across the Health Board. There are core questions relating to the patient experience enabling consistency and benchmarking across all areas. All questionnaires, where the patient experience team are sighted on, have the 3 Welsh Government core questions. These are all placed on Survey Monkey for improved data capture, reporting and analysis. The patient experience website has been updated and revised which provides information to the directorates on developing bespoke surveys ensuring they	

meet Welsh Government requirements and are placed on Survey Monkey. The website will also be updated to remind staff to feedback the outcomes of any surveys to the Patient Safety Team.	Senior Manager for Patient Experience February 2019 – completed
The Real Time Surveys are now being undertaken in the mental health and maternity services. These areas were chosen based on patient experience information analysis. A plan will be developed identifying when the current sites for real time surveys will be evaluated along with how and when the resource will be re-targeted.	Senior Manager for Patient Experience, by April 2019

Finding 2 - Reporting patient experience (Operating effectiveness)	Risk
There are a number of groups within the Directorates that receive patient experience feedback, however, there appears to be inconsistencies of which groups within the Directorates that patient experience information is reported into. Within the Therapies directorate there is a specific governance group where this information is presented. However within the Acute directorate patient experience data is reported to the Clinical Business Meeting agenda. We understand that the Health Board are in the process of developing a Quality and Patient Safety Governance Framework which will be implemented across all directorates and specialities, and this will ensure consistency in reporting across all directorates including where patient experience should be reported.	Patient experience reports are not being produced and acted upon within the Health Board.
Recommendation	**Priority level**
Management should ensure that the Quality and Patient Safety Governance Framework is agreed and implemented within the Health Board in a timely manner to enable a consistency within all directorates including which group patient experience should be reported to.	**Medium**

Management Response	Responsible Officer/ Deadline
The Executive Board and Quality Safety & Risk Committee have approved the implementation of the Quality and Patient Safety Governance framework. A comprehensive implementation plan is being developed which will support the operationalisation of the framework across the organisation.	Assistant Director Quality & Patient Experience, July 2019

Finding 3 - Patient experience plan (Operating effectiveness)	Risk
The Health Board had a Patient Experience Plan dated 2014 - 2017 and in July 2018 the Board approved an updated plan for 2018 - 2021. The current plan builds on the information contained in the previous version of the plan and outlines the Health Board's priorities in achieving excellent patient experience and to inform improvements. The plan follows Welsh Government guidance as it uses a four quadrant framework of patient feedback methods, namely 'Real Time', 'Retrospective', 'Proactive / Reactive', and 'Balancing'. When reviewing the current plan we noted that six ambitions have been set and under each, information is provided on what work has been done to date and what still needs to be achieved. In effect this forms an action plan of work, however the level of detail that was in the action plan in the 2014 - 17 Patient Experience Plan appendix, is not present. For example there is no detail on the impact of achieving the ambition, the responsible person or group, a target date and an outcome measure.	Insufficient progress in obtaining feedback from patients resulting in a lack of learning.
Recommendation	**Priority level**
A more detailed action plan should be developed to support the achievement of the actions outlined under each of the six ambitions. This should include responsible officers and timescales for completion. This will allow easier monitoring of the actions over the life of the Patient Experience Plan.	**Medium**

Management Response	Responsible Officer/ Deadline
The patient experience plan is being revised and will include a detailed implementation plan displaying timescales and leads.	Senior Manager for Patient Experience, by June 2019

Finding 4 - Informal concerns training (Operating effectiveness)	Risk
In 2016/17 the PALS team developed a training package and concerns criteria for front line staff on 'How to deal with Informal Concerns'. At that time the team undertook training with front line staff to equip them with the skills to deal with concerns 'on the spot', enabling responsive and timely action, feeding back to individuals and teams where required and learning lessons where appropriate. Management have reported in Patient Experience Plan 2018-2021 that this had a positive effect with a 50% reduction in formal concerns raised. Given the length of time that has passed, and the likely staff turnover, since the original training was delivered, staff may benefit if the training package is refreshed and delivered to those areas where it may have the greatest impact.	Insufficient progress in obtaining feedback from patients resulting in a lack of learning
Recommendation	**Priority level**
Management should consider reviewing the informal concerns training package developed by the PALS team in 2016/17 and redelivering the training to key areas.	**Low**
Management Response	**Responsible Officer/ Deadline**
A rolling programme of training developed by the PALS team has been reinstated and will be available in all ward areas over the next 9 months.	Senior Manager for Patient Experience, by December 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 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 **high impact on residual risk** exposure until resolved.

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.

Directorate reviews – Compliance - Primary Care

Internal Audit Report

2018/19

Cwm Taf University Health Board

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Opinion and key findings

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Fieldwork commencement:	22 October 2019
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Auditors:	Stuart Bodman, Emma Samways
Executive sign off:	Alan Lawrie, Interim Director of Primary, Community and Mental Health
	Steve Webster, Director of Finance
Distribution:	Craige Wilson, Assistant Director, Primary Care, Children and Community
	Sarah Bradley, Directorate Manager Primary Care & Localities Manager Merthyr/Cynon
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 Internal Audit Charter and the Annual Plan, 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 Cwm Taf University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the Primary Care Directorate's (the 'directorate') compliance with key documents such as Standing Financial Instructions, including the Scheme of Delegation, and Financial Control Procedures, was completed in line with the 2018/19 Internal Audit plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation').

The relevant Executive Director lead for the assignment is the Director of Finance.

In addition to this review, we undertook a separate review of the Directorate's management arrangements, which were reported to Audit Committee in February 2019.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to compliance with key documents, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The areas that we sought to provide assurance on were:

- Awareness levels of key documents within the directorate. For example, staff can access key documents and changes to them are appropriately communicated.
- The directorate's compliance with the relevant elements of the Scheme of Delegation.
- The directorate's compliance with relevant Financial Control Procedures (FCPs).

We met with the Head of Corporate Finance and the Assistant Director of Finance to identify the FCPs most applicable to the directorate. We were advised that the relevant FCPs were:

- Budgetary Control;
- Salaries and Wages
- Income and Debtors; and
- Inventory of Non-capital Assets.

As such, our testing of FCPs focused on these areas.

3. Associated Risks

The potential risks considered in this review were as follows:

- Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.
- Inappropriate or unauthorised decisions due to non-compliance with legislation or corporate and operational policies.
- Financial expenditure unnecessarily incurred.

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 compliance risks associated with the Primary Care Directorate is reasonable assurance.

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.

Staff within the directorate that we met had a sound understanding of the Financial Control Procedures and the relevant elements of the Scheme of Delegation. We note that staff are aware of, and have been provided with, the 'No PO, No Pay' policy.

Our testing identified that the directorate is mostly compliant with requirements set out in the FCPs and the Scheme of Delegation. We identified a small number of issues that require attention to strengthen existing levels of compliance, such as the retention of all timesheets to support payments.

In relation to the Non-Capital Assets FCP, staff within the directorate did not appear to be aware of the requirement to maintain such an inventory, and therefore did not have any records in place.

.

We also identified issues in relation to compliance with the Health Board's annual leave policy. These have been reported in our Management Arrangements report under the Workforce Management section.

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	Awareness of Key Compliance Documentation			✓	
2	Compliance with Scheme of Delegation			✓	
3	Compliance with FCPs			✓	

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

Design of Systems/Controls

The findings from the review highlighted no issue that were classified as a weakness in the system control/design for compliance within the Primary Care directorate.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as a weakness in the operation of the designed system/control for compliance within the Primary Care directorate.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Awareness levels of key documents within the Directorate

We note the following area of good practice:

- Directorate management and staff are aware of, and have been provided with, copies of the 'No PO, No Pay' policy.

We identified the following findings:

- Not all staff identified by finance had undertaken Scheme of Delegation training.
- Not all relevant staff were aware of the Health Board's Losses and Special Payments FCP.

Objective 2: Compliance to relevant elements of the Scheme of Delegation

We identified the following finding:

- An issue in relation to the appropriate approval under the Scheme of Delegation to carrying forward annual leave was identified during our workforce testing. This has been reported in our Management Arrangements report under the workforce management section.

Objective 3: The Directorate's compliance with relevant Financial Control Procedures

We note the following area of good practice:

- Our testing of budgetary control did not identify any issues.

We identified the following findings:

- The directorate does not maintain an inventory of non-capital assets in line with the requirement of the FCPs.
- A timesheet in respect of overtime worked could not be located to verify appropriate completion and subsequent authorisation by management.

7. Summary of Recommendations

The audit findings and 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**	**2**	**3**

Finding 1 - Inventory of Non-Capital Assets FCP (Operating effectiveness)	Risk
The Financial Control Procedure for Inventory of Non-Capital Assets (FCP 11) identifies the requirement for directorates to have and control an inventory of non-capital assets. Items to include on the register should be valued over £1,000 and have a useful life of more than one year. Capital items, stock and consumable items should not be included. Following our discussions with the Directorate Manager, and staff in the areas that we visited (GPOOH Service, PCSU and the two GP Managed Practices), we note that no inventory of non-capital assets is held by the directorate, as staff were unaware of the FCP and the need to maintain an inventory. There appears to be some confusion between the inventory of non-capital assets and a register of capital assets.	Financial expenditure unnecessarily incurred.
Recommendation	**Priority level**
In accordance with Financial Control Procedure 11, an Inventory of Non-Capital Assets should be compiled and maintained for all areas within the directorate.	**High**
Management Response	**Responsible Officer/ Deadline**
Agree. An inventory of non-capital assets for items over the value of £1,000 will be kept for going forward for all services within the Primary Care Directorate.	Sarah Bradley End April 2019

Finding 2 - Awareness of key documentation (Operating effectiveness)	Risk
Scheme of delegation Training in relation to the Scheme of Delegation is available via ESR. In July 2018 finance identified staff within each directorate that needed Scheme of Delegation training as part of their role. A small number of Primary Care staff were identified, but at the time of our audit fieldwork not all had completed the training module. Given their role, we would expect them to already be fully aware of the scheme, however completion of the ESR training module should still be undertaken. We also note that the Practice Managers at the two GP managed practices were not identified as needing training. However, given the autonomy that would have been in place prior to the two practices becoming managed by the Health Board, these managers should undertake this training so that they are fully aware of the requirements of the scheme. Losses and special payments Not all staff that we met as part of our fieldwork were aware of the Losses and Special Payments FCP. Whilst there has been no reported losses or disposals within the directorate during 2018/19, given the lack of awareness within some of the areas that we tested, there is a possibility that losses or disposals may have occurred and not reported in accordance with the FCP.	Inappropriate or unauthorised decisions are made if staff are unaware of the relevant key documents.

Recommendation	Priority level
1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module in ESR as soon as practically possible. 2. Consideration should be given to requiring other key staff with financial responsibilities to undertake scheme of delegation training. 3. All staff should be reminded of the existence and requirements of the Losses & Special Payments Financial Control Procedure.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agree. More robust monitoring will be put in place to ensure identified staff complete the scheme of delegation training. It is worth mentioning that access to the training via ESR is not easy and may have contributed to some individuals not being able to complete it. This has been raised with the finance and ESR teams. Agree. All staff will be made aware of the existence of the Losses and Special Payments Financial Control Procedure.	Sarah Bradley End April 2019

Finding 3 - Additional payments (Operating effectiveness)	Risk
We tested the directorate's compliance to the additional payments section of the Health Board's Salaries and Wages Financial Control Procedure. We identified one instance where the timesheet in respect of an overtime claim for work at the Wound Clinic could not be located.	Financial expenditure unnecessarily incurred.
Recommendation	**Priority level**
For the one case where a timesheet could not be found to support the overtime claim, checks should be made to ensure the payment was appropriate.	**Low**
Management Response	**Responsible Officer/ Deadline**
Teams will be reminded of the correct procedure for reporting and approving of overtime and the need to retain safely all documentation.	Sarah Bradley End April 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 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 **high impact on residual risk** exposure until resolved.

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*

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Risk Management

Internal Audit Report

Cwm Taf University Health Board

March 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Follow up of outstanding recommendations (2017/18 Internal Audit Report).
Appendix C Assurance opinion and action plan risk rating

Review reference:	CTU-1819-03
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Fieldwork commencement:	2 November 2018
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Executive sign off:	Gwenan Roberts – Interim Board Secretary
Distribution:	Gwenan Roberts – Interim Board Secretary
Committee:	Audit Committee

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1. Introduction and Background

In line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board' or the 'organisation'), a review of the arrangements for Risk Management was undertaken.

Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives.

Risk management underpins the governance arrangements for the Annual Governance Statement. The Chief Executive, as Accountable Officer, carries ultimate responsibility, delegated by the Health Board, for assuring the quality of the services provided, and for ensuring the implementation of effective governance arrangements.

The 2017/18 audit review of risk management primarily focussed on the process and systems in place within directorates. The current year's review focused on the organisational risk register and corporate monitoring.

The relevant lead for the review is the Interim Board Secretary.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the Health Board's risk management processes. The review sought to provide assurance to the Health Board's Audit Committee that risks material the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on were:

- An up to date, comprehensive risk management strategy and policy is in place that provides clear guidance on the organisation's approach to risk management, including the responsibilities of individuals and committees.
- The risk management strategy and policy is appropriately applied including application of risk appetite.
- There are clear links between the Organisational Risk Register and the Board Assurance Framework.
- Monitoring and scrutiny of the Organisational Risk Register and Board Assurance Framework takes place at appropriate committees with amendments clearly identifiable and justified.

In addition, we followed up on the progress made against the recommendations made in the 2017/18 risk management audit review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Risks are not effectively managed due to the lack of an approved strategy / policy and structure.
- Risk becomes an issue, as staff are unaware of the process for managing them.
- Risks to the achievement of the Health Board's strategic objectives are not effectively managed.

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 risk management arrangements is **Reasonable assurance**.

RATING	INDICATOR	DEFINITION
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.

We identified that overall there are suitable arrangements in place for control and governance of risk management with good strategy, policy and procedural documents.

We identified one high priority finding relating to monitoring of the Board Assurance Framework (BAF), as it has not been regularly updated or been formally approved by either the Board or an appropriate committee since May 2017.

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	Risk management strategy and policy is in place.				✓
2	The risk management strategy and policy is appropriately applied.			✓	
3	There are clear links between the Organisational Risk Register and the Board Assurance Framework.		✓		
4	Monitoring and scrutiny of the Organisational Risk Register and Board Assurance Framework.			✓	

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

Design of Systems/Controls

We did not identify any findings from the review that are classified as weaknesses in the system control/design for risk management.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed system/control for risk management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: An up to date, comprehensive risk management strategy and policy is in place.

We note the following areas of good practice:

- The Health Board has in place a Risk Management Strategy and Risk Management procedure document. Both have recently been updated and approved by the Quality, Safety & Risk Committee. These are supported by an overarching Risk Management Policy, also approved by the Quality, Safety & Risk Committee.
- Risk documents are easily accessible to staff via the Health Board's SharePoint.

We did not identify any findings under this objective.

Objective 2: The risk management strategy and policy is appropriately applied including application of risk appetite.

We note the following area of good practice:

- The Health Board has set its strategic approach to risk-taking by defining its risk appetite thresholds within its risk management strategy.

We identified the following finding:

- The organisation's risk appetite statement, contained within the risk management strategy, is due for formal review every 5 years. However, we feel that a more frequent review of risk appetite is required.

Objective 3: There are clear links between the Organisational Risk Register and the Board Assurance Framework.

We identified the following finding:

- The Health Board's BAF is currently evolving, however, since May 2017, there is no evidence of the BAF being sighted by the Board or the Quality, Safety & Risk Committee for monitoring.

Objective 4: Monitoring and scrutiny of the Organisational Risk Register and Board.

We note the following areas of good practice:

- All organisational risks have a lead Executive Director, with the risk assigned to either the Board, or an appropriate sub-committee of the Board.
- Executives, as risk owners, are appropriately sighted and involved in the development of the organisational risk register through their attendance at committees and the Executive Management Board.
- From our review of the organisation risk register, no organisational risks straddle more than one assuring committee.
- The full organisational risk register is received at the Quality, Safety & Risk Committee, and where appropriate, alternative sub-committees of the Board.

We identified the following finding:

- Our audit fieldwork identified that there is a lack of clear evidence to confirm that there has been detailed scrutiny to support the movements in risk scores.

Objective 5: Follow up of 2017/18 recommendations.

In summary, progress against the five agreed recommendations that required implementation is as follows:

Priority rating	No. of recommendations to be implemented	Fully implemented	Partially implemented	Not Implemented	Closed*
High	1	-	1	-	-
Medium	2	-	1	1	-
Low	2	1	-	-	1
Total	**5**	**1**	**2**	**1**	**1**

*Management have made a decision to take no further action in relation to this low priority recommendation.

The action plan within Appendix B provides full details of the findings, priority ratings and management responses from the original review, along with details of the current position, as verified by our follow-up work. Revised recommendations and priority ratings are included where necessary.

7. Summary of Recommendations

The audit findings and 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**	**2**	**0**	**3**

Finding 1 - Board Assurance Framework (Operating effectiveness)	Risk
The HM Treasury Guidance on Assurance Frameworks (2012) defines an assurance framework as: *'An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect'.* The Health Board's Risk Management Strategy refers to the Board Assurance Framework (BAF) as being one of the tools that the Board will use to manage risk. The strategy goes on state that the BAF should be submitted to Quality, Safety and Risk (QS&R) Committee for monitoring purposes. However, a report that went to QS&R in September 2018 states: *'The Assurance Framework reports into the Audit Committee for periodical review, monitoring and scrutiny and also features (at least annually) on the agenda of the Board'.* We subsequently reviewed the minutes of the Board meetings and Audit Committee meetings. This highlighted that the last time the BAF was presented to Audit Committee was in February 2017, and to the Board was in November 2018. However, the minutes from the November Board meeting stated the need to discuss the BAF in more detail at the Integrated Governance Committee prior to it being approved by the Board. This is targeted for April 2019. Prior to this, the Board last received the BAF in May 2017.	Risks to the achievement of the Health Board's strategic objectives are not effectively managed.

We note that the BAF was on the forward work programme to go to the September 2018 and January 2019 Audit Committees. However, it was not submitted to either as it had not been formally approved by the Board.	
Recommendation 1	**Priority level**
1. The BAF should be updated for alignment with the current organisational risk register, approved by the Board and monitored on an ongoing basis. It should be ensured that the BAF remains a live document, linked to the risk register. 2. Clarity should be sought as to which committee will be responsible for monitoring the BAF and ensuring it remains a current document.	**High**
Management Response	**Responsible Officer/ Deadline**
Agreed. In view of the changes to Cwm Taf in terms of the Bridgend boundary change the Board will review the organisational risk register and Board Assurance Framework at a Board development session. The Board will consider at the session which committee will oversee both the risk register and assurance framework.	Interim Board Secretary working with the Chair and Chief Executive June 2019

Finding 2 – Review of risk appetite (Operating effectiveness)	Risk
An organisation's risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take in pursuit of value. Alternatively, it's the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives. The Health Board's risk appetite is incorporated within the Risk Management Strategy, which was approved by the Quality, Safety and Risk Committee in May 2018. The strategy is due for an informal review every year, and a formal review every five years. However, the risk appetite of the Health Board may change depending on its objectives, priorities, changes in key officers. Therefore, incorporating the review of the risk appetite into the same cycle as the formal five-year review of the Risk Management Strategy may be too long.	Risks to the achievement of the Health Board's strategic objectives are not effectively managed.
Recommendation 2	**Priority level**
The risk appetite of the Health Board should be reviewed more regularly than the current five-year cycle implied as part of the Risk Management Strategy review.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed. The process of reviewing both the organisational risk register and Board Assurance Framework will be discussed fully at a Board development session and the processes and timescales, as well as the assuring Committee will be agreed.	Interim Board Secretary working with the Chair and Chief Executive June 2019

Finding 3 - Scrutiny of the organisational risk register (Operating effectiveness)	Risk
We reviewed a sample of five corporate risks where the risk score had reduced to identify the rationale for the amendments to the risk scores, and to establish the level of scrutiny that occurred at the responsible assuring committee. In two of the five cases, the reduction in risk score had meant a drop in overall rating from High to Moderate. We were unable to sight a documented rationale for the movements in the risk scores, or changes in the level of control percentages recorded on the 'risk on a page' reports. We were informed by the Interim Board Secretary that changes were made at the request of the Executive lead for the respective risk, and are based on their professional judgement. Attendance at the Finance, Performance and Workforce (FP&W) Committee and QS&R Committee and a review of committee minutes established that reports are taken to these meetings highlighting requests for changes to scores, or narrative for the risks they are responsible for monitoring. However, we could not evidence detailed scrutiny or challenge of the reasons behind the requested score changes, especially where such changes impacted on the overall risk rating. Our review of the September QS&R Committee minutes noted: *"That the Committee could take assurance that mitigations were being undertaken by Directorates in relation to risks and that risks would be brought to the attention of the Committee where necessary."* However, our recent audit work of risk	Risks to the achievement of the Health Board's strategic objectives are not effectively managed.

monitoring undertaken in directorate reviews has highlighted varying levels of maturity in relation to risk management.	
Recommendation 3	**Priority level**
Where amendments to risk scores are requested a clear audit trail should be in place to support the reason for the change and the assigned committee should satisfy itself that changes in the score and overall rating are justified.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. Once the new organisational risk register is developed following the Bridgend boundary change a new process will be in place which will capture the changes made to any risks so that a clear audit trail will be in place.	Interim Board Secretary Summer 2019 (once the new organisational risk register is in place).

Appendix B - Follow up of recommendation made in 2017/18 Internal Audit Report.

Original Finding 1 - Cancer services risks (Operating effectiveness)	Original Risk
Health Board procedures require risks to be recorded on the Datix system and managed through departmental and directorate risk registers that feed into the organisational risk register. Cancer services are provided by a range of directorates including Radiology, Pathology, General Surgery, Acute Medicine, Anaesthetics, Critical Care & Theatres and Head and Neck. Consequently, the management of cancer services' risks is spread across the individual directorate risk registers. The Cancer Implementation Group (CIG) is responsible for monitoring the Health Board's Cancer Delivery Plan and is the main governance group for cancer services. Our review of the minutes of the last three meetings of the CIG identified that risks were being were being discussed and managed at the CIG. However, we note that these risks were not being formally assessed and recorded on the Datix system and therefore are not captured on a formal risk register. As such, these risks do not appear to be managed in accordance with UHB risk management procedures.	Risks to the achievement of the organisations objectives may not be effectively managed at a directorate level to allow mitigation.
Original Recommendation	**Original Priority level**
Risks identified at Cancer Implementation Group meetings should be formally assessed in accordance with UHB Risk Management procedures and notified to the relevant directorate for input to the Datix system and subsequent review as part of the directorate risk register with appropriate monitoring by the CIG.	**High**

Original Management Response	Original Responsible Officer/ Deadline
1. Risk Register to be developed from DATIX initially for review at Cwm Taf Cancer Implementation Group (CIG).	Wayne Jenkins May 2018
2. Risk Register to be reviewed at each CIG meeting with oversight at the Cwm Taf Cancer Steering & Strategy Group (CSSG).	Wayne Jenkins May 2018
3. Additional Risks identified at CIG to be notified to relevant directorates.	Rebecca Luffman May 2018
4. Directorate leads to undertake risk assessment and Datix entry for any risks identified at CIG.	Directorate Leads May 2018
Current position	
The Head of Business and Operational Support has advised us that the following actions were agreed in the Cancer Implementation Group (CIG) in June 2018. Cancer related risks are documented on the Datix system by individual clinical Directorates. A summary will be collated into a risk register. The Cancer Services Strategy and Steering Group (CSSG) meeting will undertake an initial review of risks identified within this register. Following this, risks will be monitored at each CSSG meeting (held every other month). Any significant (high-rated) risks will be escalated to the Cancer Implementation Group for review. Discussion of these risks will be documented in the meeting action log. Communication and actions will be fed down to the CSSG for dissemination to the relevant clinical Directorate for urgent resolution. Flowchart attached for agreed risk process. The Directorates continue to undertake risk assessments and Datix entry for cancer related risks.' A copy of the flow chart that supports this process was provided and our review of the CIG minutes from the June 2018 meeting confirmed that this process was agreed. However, we were informed that two of the last three CSSG meetings have been cancelled and this item has been re-scheduled for discussion at the January 2019 meeting. At the time of completing the audit fieldwork, we were unable to obtain a further update from management as to whether the January	

meeting took place and if the process described is now in place.

Although a revised process has been developed, we have not been able to evidence it being applied therefore whilst we consider this action as **partially implemented** the priority rating of High has remained.

Updated Recommendation	Updated Priority Level
It should be ensured that the process described in the cancer risk flow chart is adhered to with departments capturing all relevant cancer risks on Datix, the collated risk register being reviewed at the Cancer Services Strategy and Steering Group and any significant risks escalated to the Cancer Implementation Group. Actions from the Cancer Implementation Group should be disseminated back down to relevant directorates.	**High**
Updated Management Response	**Updated Responsible Officer / Deadline**
The following actions were agreed in the Cancer Implementation Group on 13th June 2018: Cancer related risks are documented on the Datix system by individual clinical Directorates. A summary will be collated into a risk register. The Cancer Services Strategy and Steering Group (CSSG) meeting will undertake an initial review of risks identified within this register. Following this, risks will be monitored at each CSSG meeting (held every other month). Any significant (high-rated) risks will be escalated to the Cancer Implementation Group for review. Discussion of these risks will be documented in the meeting action log. Communication and actions will be fed down to the CSSG for dissemination to the relevant clinical Directorate for urgent resolution. Flowchart attached for agreed risk process. The Directorates continue to undertake risk assessments and Datix entry for	Cancer Manager/ Cancer Clinical Lead and lead nurse July 2019

cancer related risks. Unfortunately CSSG meetings have been cancelled and this item had been scheduled for discussion at the January 2019 meeting. The Cancer Manager – Wayne Jenkins met with the Cancer Clinical Lead, Balan Palanaippan who was recently appointed. The Cancer lead is writing to the Medical Director and Chief Operational Officer regarding the lack of engagement, priority and focus on cancer services within the health board. The Cancer Manager, clinical lead and lead nurse are developing the vision for how cancer services will be managed post 1 April to ensure that focus is provided for cancer services addressing the risk and governance issues across the new HB. ***Audit note:*** *While we acknowledge the updated management response, we would encourage that through the CSSG cancer risks are monitored and that there is a clear flow of information up to the CIG and down to directorates.*	

Original Finding 2 - Cancer services risk register (Control Design)	Original Risk
As part of our audit fieldwork a risk register was generated from the Datix system of all live 'Cancer Services' risks i.e. risks that directorates have categorised as relating to 'Cancer Services'. We note that the register contained only nine 'live' risks drawn from six directorates. We understand that neither Cancer Services management nor the CIG were presently reviewing directorate level cancer services risks recorded on the Datix system and that these risks are reviewed at a directorate level. A review of the minutes of the last three CIG meetings identified a large number of 'cancer' related risks, many of which were not recorded on the Datix system	Risks to the achievement of the organisations objectives may not be effectively managed at a directorate level to allow mitigation.
Original Recommendation	**Original Priority level**
Cancer Services Management should review all cancer related risks recorded on the Datix system and report them to the CIG. Cancer Services management should utilise the Datix system to compile a Cancer Services risk register from the cancer related risks recorded by the various directorates on the Datix system and those identified by the group. This should then be reviewed regularly at CIG meetings. Risk owners should be identified to ensure there is not duplication of effort or inconsistent approaches between the CIG monitoring and the directorate monitoring.	**Medium**

Original Management Response	Original Responsible Officer/ Deadline
Risk Register to be developed from DATIX initially for review at Cwm Taf Cancer Implementation Group (CIG).	Wayne Jenkins May 2018
Risk Register to be reviewed at each CIG meeting with oversight at the Cwm Taf Cancer Steering & Strategy Group (CSSG).	Wayne Jenkins May 2018
Additional Risks identified at CIG to be notified to relevant directorates.	Rebecca Luffman May 2018
Directorate leads to undertake risk assessment and Datix entry for any risks identified at CIG.	Directorate Leads May 2018
Current position	
As original finding 1, above - We consider this action **partially implemented** and have kept the priority level as medium.	
Updated Recommendation	**Updated Priority Level**
It should be ensured that the process described in the cancer risk flow chart is adhered to with departments capturing all relevant cancer risks on Datix, the collated risk register being reviewed at the Cancer Services Strategy and Steering Group and any significant risks escalated to the Cancer Implementation Group. Actions from the Cancer Implementation Group should be disseminated back down to relevant directorates.	**Medium**

Updated Management Response	Updated Responsible Officer / Deadline
A review of all Directorates Risk Registers has been planned which will capture cancer services from across the organisation. Chris Beadle will lead the work from the Datix system and will work with all Assistant Directors and Directorate Managers.	Chris Beadle and Wayne Jenkins (with Assistant Directors and Directorate Managers) By Dec 2019

Original Finding 3 - Ophthalmology risk register (Operating effectiveness)	Original Risk
Our review of a sample of three ENT Heads of Service meeting minutes confirmed that Ophthalmology risks were being actively managed. However, the Ophthalmology risk register maintained on the Datix system was in need of updating. For example, no new risks had been added to the register since October 2016 and some of the risk were assigned to an owner (LT) that was no longer employed within Ophthalmology. In addition, the register contained a number of live risks dating back to 2013 that we would expect to have been resolved and closed. For example, risk ID 753 (sun shining through treatment room window into patients eyes), and risk ID 664 (lack of wheelchair access to room CE08), both of which were still rated as High. Some of the controls / mitigating actions were also incomplete.	Risks to the achievement of the organisations objectives may not be effectively managed at a directorate level to allow mitigation.
Original Recommendation	**Original Priority level**
The Ophthalmology risk register should be reviewed and updated. A review of the updated risk register should be a standing agenda item for ENT Heads of Service meetings.	**Medium**

Original Management Response	Original Responsible Officer/ Deadline
The Directorate has raised this in its integrated business and governance meeting and the lead manager for governance has been tasked with updating the risk register by the end of March 2018. A number of meetings have been held between Heads of Service and the Patient Quality and Safety business partners.	Jonathan Arthur April 2018
Current position	
At the completion of our audit fieldwork management had not provided an update in relation to the implementation of this recommendation. We therefore consider it to be **not implemented.**	
Updated Recommendation	**Updated Priority Level**
The Ophthalmology risk register should be reviewed and updated. A review of the updated risk register should be a standing agenda item for ENT Heads of Service meetings.	**Medium**
Updated Management Response	**Updated Responsible Officer / Deadline**
A review of all Directorates Risk Registers has been planned which will capture ophthalmology service. Chris Beadle will lead the work from the Datix system and will work with the Head and Neck Directorate the Assistant Director.	Chris Beadle and the Head and Neck directorate By July 2019

Original Finding 4 - Procedures (Control Design)	Original Risk
It was identified that the Health Board's Risk Management Policy is dated 2017 and therefore not due for review until 2020. However the Risk Management Strategy and Risk Assessment Procedure were due for review in 2017 and 2016 respectively.	Risks may materialise if staff are unaware of the process for managing them.
Original Recommendation	**Original Priority level**
The Risk Management Strategy and Risk Assessment Procedure should be reviewed and up to date versions made available to all staff.	**Low**
Original Management Response	**Original Responsible Officer/ Deadline**
The Risk Management Strategy and Risk Assessment Procedure will be updated by the end of April 2018 and presented to the May 2018 meeting of the Quality, Safety and Risk Committee. Following ratification by the Quality, Safety and Risk Committee the new documents will be made available to all staff via the Health Board's intranet pages.	Robert Williams - Board Secretary / Director of Corporate Services & Governance Chris Beadle – Head of Health, Safety & Fire (May 2018)
Current position	
We consider this action to be **fully implemented.**	

Original Finding 5 - Staff risk assessor training (Operating effectiveness)	Original Risk
Risk Assessment training is available from the Health & Safety department. However, risk assessments, as per UHB Risk Management procedures, are not presently being undertaken by Cancer Services for risks discussed at CIG meetings.	Risks may materialise if staff are unaware of the process for managing them.
Original Recommendation	**Original Priority level**
A sufficient number of staff within Cancer Services should be trained to complete risk assessments in accordance with UHB Risk Management procedures.	**Low**
Original Management Response	**Original Responsible Officer/ Deadline**
Supervisory and management staff to undertake risk assessment training.	Wayne Jenkins May 2018
Current position	
Management have stated that as risks sit within the individual clinical directorates, a decision has been made that there are already enough staff specifically trained in undertaking risk assessments, therefore no further training is required. We consider this action to be **closed.**	

Appendix C - 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 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 **high impact on residual risk** exposure until resolved.

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.

DRAFT

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

Cwm Taf Morgannwg University Health Board

Internal Audit Plan 2019/20

April 2019

NHS Wales Shared Services Partnership
Audit and Assurance Services

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Appendix A Internal Audit Plan 2019/20

Appendix B Key Performance Indicators

Appendix C Internal Audit Charter 2019

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.

On 1 April 2019, the responsibility for commissioning healthcare services for the people in the Bridgend County Borough Council (BCBC) area moved from Abertawe Bro Morgannwg University Health Board (ABMUHB) to Cwm Taf University Health Board (CTUHB), moving the health board boundary accordingly. As such, this Plan considers the Internal Audit requirements for the newly named organisation, Cwm Taf Morgannwg University Health Board.

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.

1.1 Joint Committees

The proposed Plan includes our planned activities with regards to the Health Board's two joint committees hosted by the Health Board: Welsh Health Specialised Services Committee (WHSSC); and Emergency Ambulance Services Committee (EASC). These activities are included as an additional section in Appendix A.

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
- 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.

As part of our planning we have developed an understanding of the issues and risks relating to the Bridgend boundary change that comes into effect on 1 April 2019. This includes considering the previous years' internal audit activities at ABMU to help inform our risk based approach to planning this year's programme of work.

Furthermore, our planning takes into account the NHS Wales Planning Framework 2019/20 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 Integrated Medium Term Plan (IMTP) and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

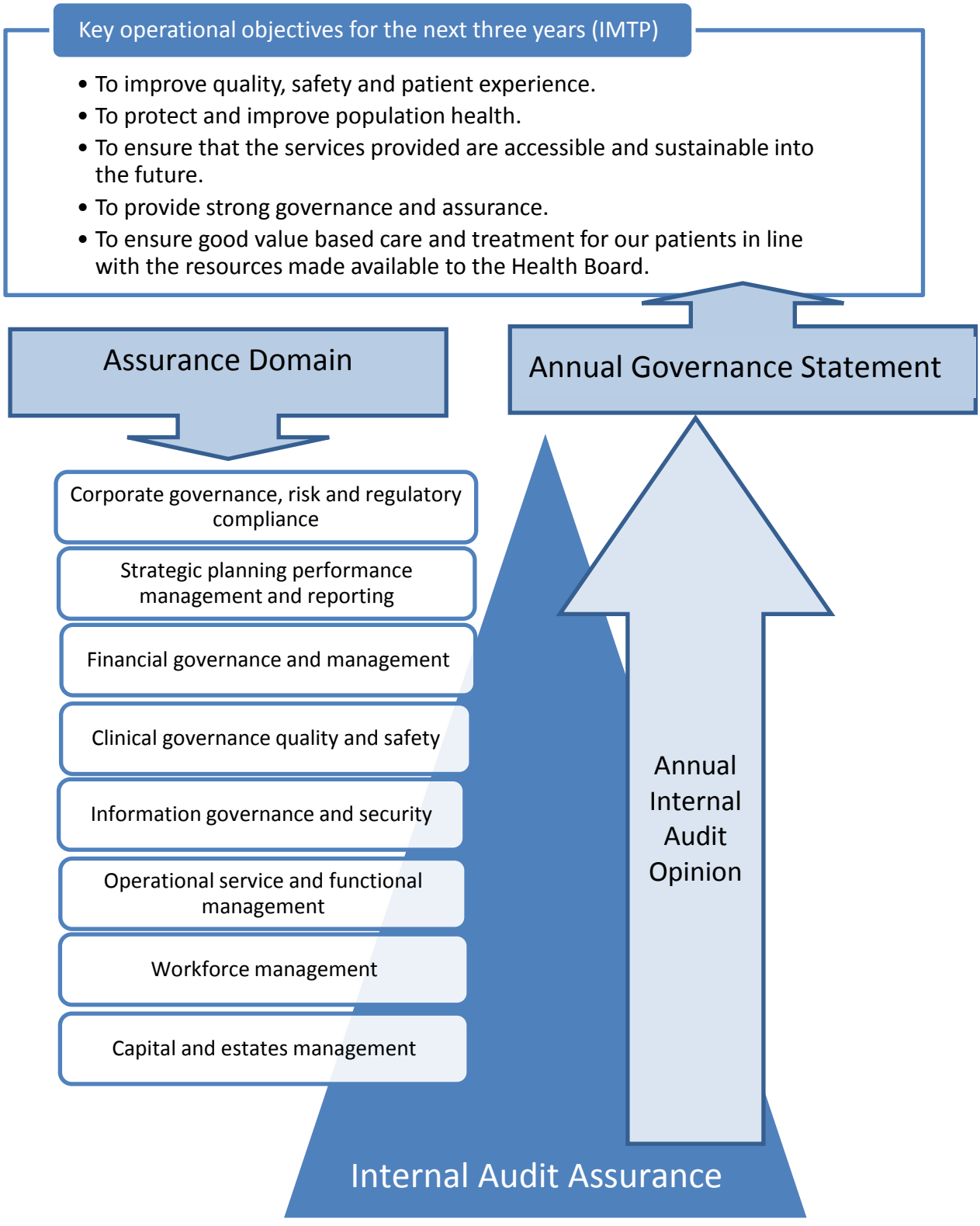
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

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

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

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

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

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

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and Quality, Safety and Risk 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;
- planned audit coverage of systems and processes provided through NHS Wales Shared Services Partnership (NWSSP), WHSSC and EASC;
- 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 review bodies including Wales Audit Office (WAO) and Health Inspection Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

In addition, to understand the risks matters related to the boundary change, the Head of Internal Audit has attended the Bridgend boundary change governance and communications workstream meetings, and has worked with the Head of Internal Audit for Abertawe Bro Morgannwg University Health Board.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met with a number of Health Board Executives and the Chair of the Audit Committee to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's executive team, the Chair of the Audit Committee and the Chairman of the Board.

To inform our planning in relation to the Health Board's hosted bodies we have also met with the following key personnel during the planning process:

- Dr Sian Lewis, Managing Director (WHSSC);
- Stephen Harrhy, Director and Chief Ambulance Services Commissioner (EASC);

In addition, the Head of Internal Audit has worked with the Head of Internal Audit at Abertawe Bro Morgannwg University Health Board to develop an understanding of the issues and risks relating to the Bridgend boundary change that comes into effect on 1 April 2019.

The draft Plan has been provided to the Health Board's Executive Management team to ensure that Internal Audit effort 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 by our Specialist Services Unit (SSU). 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. As 2019/20 will be the first year that services provided to the Bridgend population with be delivered by the Health Board, we will periodically review our risk assessment and rolling 3-year audit plan 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 your External Auditor 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 980 days plus 75 days for the Joint Committees 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.

We held discussions with management where a range of potential reviews were considered for inclusion within the plan. With the services for the Bridgend population transferring to the Health Board it is facing changing needs, and increased risks and challenges. This year, following our planning discussions with management, we have significantly increased the number of planned days to deliver the programme of audit work for 2019/20.

If additional work or support or further input necessary to deliver the plan is required during the year a fee may be required to be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit and Corporate Governance Committee for approval.

This total resource allocation covers the servicing of the local audit plan (980 days), plus 75 days for the audit of WHSSC and EASC.

This year's plan reflects the transfer of services in the Bridgend area from 1 April 2019. As such, the plan reflects the additional risks of the new combined Health Board, as well as including audit time to consider a number of transitional risks.

At this stage, the top-slice funding passed to NWSSP equates to 550 days for the former Cwm Taf UHB and 75 days for WHSSC and EASC. In 2018/19 the former Cwm Taf UHB also purchased an additional 105 days at a direct cost of £31,500 (a daily rate cost of £300). As such, there is an estimated gap of 430 days that needs to be resourced. We will update the Audit Committee when the funding mechanism for this additional work has been agreed.

Please note that as we have not increased our daily rate for a number of years, our planning assumptions for 2019/20 are based on £309 per audit day.

We set out a summarised analysis in the table below:

	2018/19	2019/20
Core days	550	550
Purchased days	105	100
New core days	-	240
Transitional days	-	90
Total	**655**	**980**
WHSSC/EASC	75	75

In addition, capital audit work in relation to the Prince Charles Hospital Project will be charged for separately on the basis of a separately agreed project plan. (see p 19)

The internal provision through NWSSP Audit & Assurance Services represents best value for NHS Wales in comparison with external commercial rates for the equivalent provision of these professional services.

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 will 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.

Paul Dalton

Head of Internal Audit (Cwm Taf Morgannwg University Health Board)

Audit & Assurance Services

NHS Wales Shared Services Partnership

Cwm Taf Morgannwg University Health Board

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Corporate governance, risk and regulatory compliance						
Annual Governance Statement	1		Mandatory review.	5	Board Secretary/ Corporate Director and Director of Governance	Q1
Risk management	2	X	Effective risk identification and mitigation arrangements in relation to risks identified in the IMTP. – Ensuring that risks relating to Bridgend are captured in governance arrangements.	20	Board Secretary/ Corporate Director and Director of Governance	Q2
Raising Concerns - follow up	3		Limited assurance report in 2018-19.	5	Board Secretary/ Corporate Director and Director of Governance	Q1
Governance arrangements of Board committees	4	X	Consideration of Quality Safety and Risk committee.	15	Board Secretary/ Corporate Director and Director of Governance	Q1

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Nurse Staffing Levels Act (Wales) 2016	5	X	Compliance with, and reporting of, the Act through committee.	20	Director of Nursing, Midwifery and Patient Care	Q2
Health and Care Standards	6		Consideration of the application of the standards.	25	Director of Nursing, Midwifery and Patient Care	Q4
Culture	7	X	Ensuring that the Health Board's values and behaviours are promoted.	20	Board Secretary/ Corporate Director and Director of Governance	Q2
Corporate governance, risk and regulatory compliance domain sub-total				**110 days**		
Strategic planning, performance management and reporting						
IMTP / Efficiency Board	8	X	Governance arrangements and implementation of the cross cutting theme identified in the IMTP - Bridgend element to consider reporting to EB.	25	Director of Planning and performance	Q2

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
De-escalation project	9	X	Progress against actions and timeline.	20	Board Secretary/ Corporate Director and Director of Governance	TBC
Transformation project	10		Effectiveness of projects - Consider link into 'A Healthier Wales' and IMTP. The HB is set up effectively to take on the investment anticipated, and deliver the changes agreed.	15	Director of Planning and performance	Q3
Strategic planning, performance management and reporting domain sub-total				**60 days**		
Financial Governance and management						
Welsh risk pool claims	11		Mandatory review	2	Director of Nursing, Midwifery and Patient Care	Q4
Core financial systems	12	X	Cyclical review of the Health Board's financial systems	20	Director of Finance	Q4

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Medical agency usage	13	X	Use of the new Retinue Bridge system and use of agency.	20	Director of Finance	Q3
Nursing agency usage	14	X	The use of agency staff and the link to patient experience.	20	Director of Workforce and Organisational Development	Q3
Financial Governance and management domain sub-total				**62 days**		
Clinical governance, quality & safety						
Annual quality statement	15		Mandatory review	5	Board Secretary/ Corporate Director and Director of Governance	Q1
Health & Safety management	16		Ensuring that appropriate governance and reporting arrangements are in place.	20	Director of Planning and performance	Q2
Incident reporting / Putting things right	17		Governance of arrangements	20	Director of Nursing, Midwifery and Patient Care	Q1

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Clinical governance quality & safety domain sub-total				**45 days**		
Information Governance and Security						
Digitisation	18		Implementation and reporting of the digital strategy	15	Chief Operating Officer	Q2
data quality review	19		Focus to be determined	15	Director of Planning and performance	Q3
Information governance - Medical records management	20	X	Governance, control and reporting arrangements	15	Chief Operating Officer	Q2
Freedom of Information	21		Governance, control and reporting arrangements	13	Chief Operating Officer	Q1
Information Governance and Security domain sub-total				**58 days**		
Operational service and functional management						
Directorate reviews – Management Arrangements x5	22-26	X	Five directorate reviews – Head & Neck; Pathology; Acute Medicine and	150	Various	Q1-4

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
The outcomes of these reviews will inform our assessments of assurance within the related domains. In addition, to the areas of focus undertaken in previous years, this year we will also consider quality arrangements within the directorates that we review.			Therapies. Estimated 30 days per review. Similar to last year these reviews will include the directorates approach to risk, planning and performance, workforce, and governance arrangements.			
Directorate reviews – Compliance x5	27-31	X	Five directorate reviews. Estimated 15 days per review. The directorates that are reviewed will align with the directorates in the management arrangements review.	75	Various	Q1-4
Bridgend directorates	32-34		Will be similar in nature to directorate reviews above.	100	TBC	TBC
Primary Care cluster plans	35		Alignment with Health Board IMTP.	15	Director of Primary, community and Mental Health	Q1

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Outpatients	36	X	Consideration of controls to mitigate risks.	17	Chief Operating Officer	Q2
Operational service and functional management domain sub-total				**357 days**		
Workforce management						
Consultant job planning	37		To consider if there standardised job plans in place, are they applied properly, and are they appropriate and followed.	20	Director of Workforce and OD	Q1
Retention of staff - follow up	38		To follow up on the progress made against the recommendations from our 2018/19 review.	5	Director of Workforce and OD	Q1
Medical staffing	39		Review of staffing arrangements in Bridgend area.	10	Director of Workforce and OD	Q3
Rostering	40		Governance and monitoring arrangements for rostering.	20	Director of Workforce and OD	Q3

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Workforce management domain sub-total				**55 days**		
Capital and Estates						
Management of major capital	41	X	Focus to be agreed.	25	Director of Planning and Performance	Q1
Environmental sustainability reporting	42		Mandatory review	10	Director of Planning and Performance	Q1
Management of Prince Charles Capital project	43		To continue the support provided to the Health Board with this ongoing project. Note days to support this review are to be agreed and funded separately.	TBA	Director of Planning and Performance	Q1-4
Planned preventative maintenance	44		Governance and monitoring arrangements.	20	Director of Planning and Performance	Q2

Planned output	Audit Ref	Risk Register/ key area of focus	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Medical equipment review including - Follow up	45	X	Arrangements within Bridgend area and follow up.	20	TBC	Q1
Capital and Estates domain sub-total				**75 days**		
Audit Contingency		-	-	8 days	N/A	-
Follow up of ABMU 2018/19 reports		-	To follow up reports issued as 'limited assurance' to ABMU	20 days	N/A	Q1-4
Transitional work		-	Integration of Bridgend services	70 days	N/A	Q1-4
Audit management and reporting				**60 days**		
Indicative total days 2019/20				**980 days**		

WHSSC and EASC

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
WHSSC						
Quality team implementation	46	-	Advisory work to consider how quality team are developing.	10	WHSSC	Q3
Information governance review	47	-	Governance arrangements in place at WHSSC.	15	WHSSC	Q2
Directorate review of cardiac	48	-	Review of control, governance, monitoring and reporting	15	WHSSC	Q1
WHSSC sub-total				**40 days**		
EASC						
Amber review	49	-	Review of progress against findings of the review.	15	Director	Q3
NEPTS follow up	50	-	To follow up on the progress of transfer.	10		Q3
EASC sub-total				**25 days**		

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Audit management and reporting				**10 days**		
Indicative total days for 2019/20				**75 days**		

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 [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

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

Cwm Taf Morgannwg University Health Board

INTERNAL AUDIT CHARTER

April 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 Cwm Taf Morgannwg University Health Board's (the 'organisation') 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 Cwm Taf Morgannwg University Health Board (the 'organisation') 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 Cwm Taf Morgannwg University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Finance and Board Secretary.

1.3 The organisation currently hosts two bodies that we undertake internal audit reviews, Welsh Heath Specialised Service Committee (WHSSC) and Emergency Ambulance Services Committee (EASC). The principles of the Internal Audit Charter apply equally to all of the audit work delivered for these two bodies and their management. Work for the Joint Committees is delivered through their respective structures.

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 Cwm Taf Morgannwg University 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;
- 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.

[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.*

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 Risk Committee, and the Integrated Governance Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Finance 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 Director of Finance and 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.

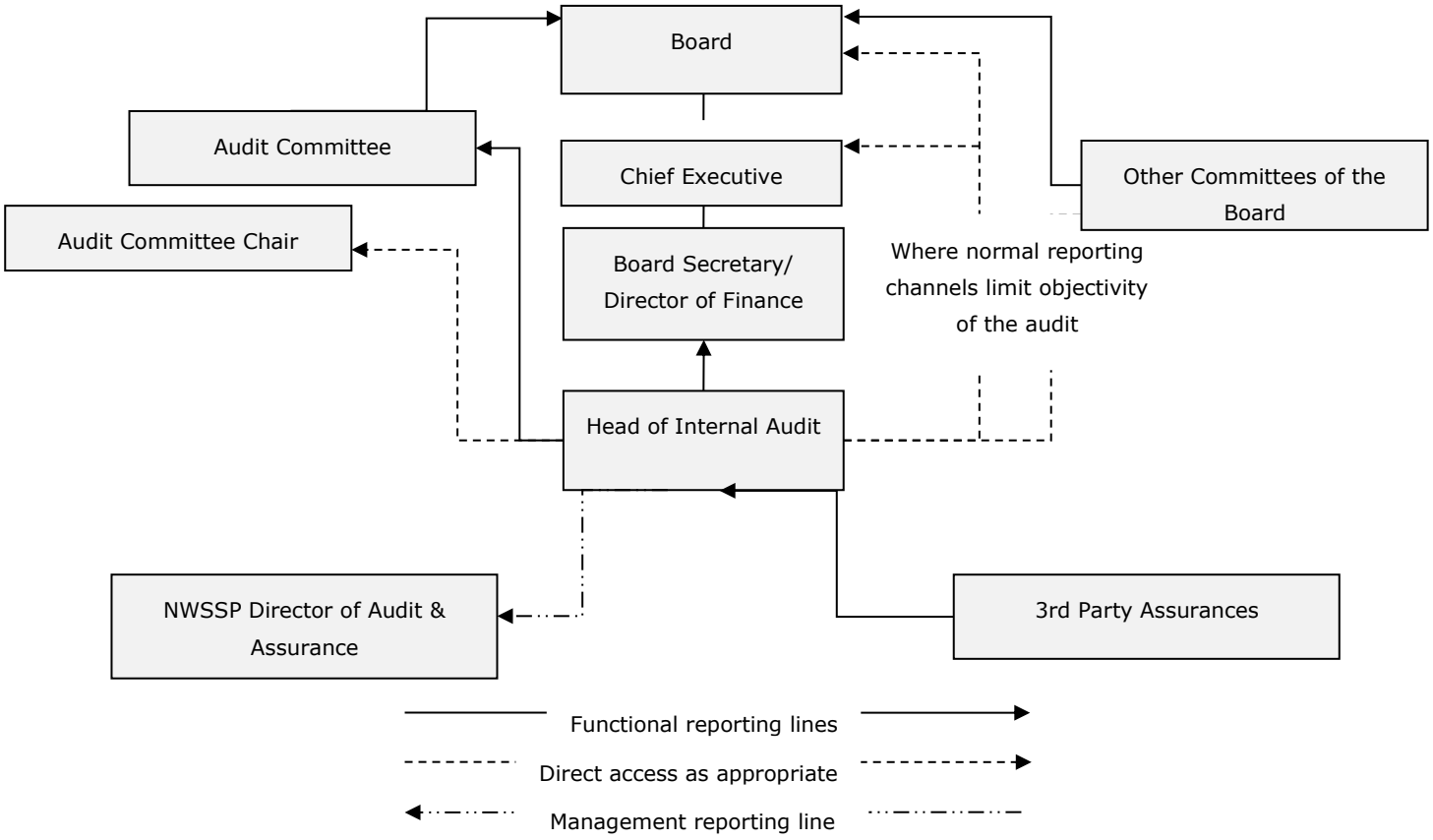
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems that are being operated by organisations outside of the remit of the Accountable Officer, or through a shared or Joint Committee arrangement.

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. 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 2018) 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 Governance and Accountability modular assessment and 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. In the case of the Cwm Taf Morgannwg University Health Board consideration is given to two of the hosted bodies, WHSSC and EASC, when developing the plan and delivering audit assignments. The detailed of audit work will be agreed with each hosted body on a risk based approach in the same way as set out above.

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 below.

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.

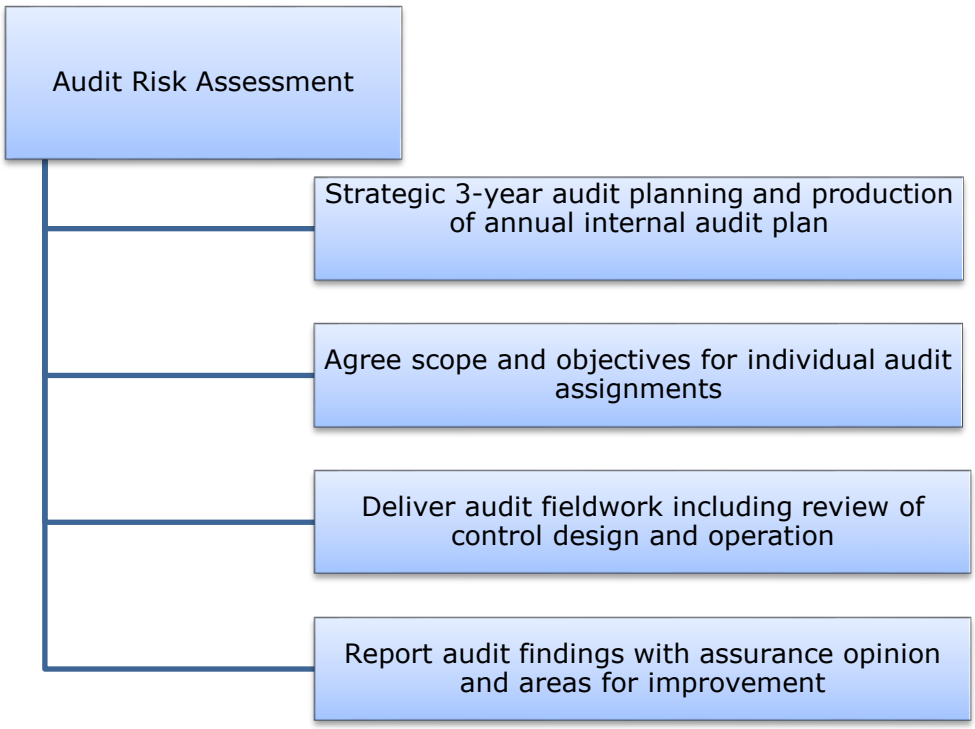
8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

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.

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 Director of Finance and Board Secretary. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach



9 Reporting

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

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

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

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

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

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

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

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

- An overall annual opinion is not provided for the hosted bodies.
- 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 to this Charter:

- 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 to this Charter. 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 15 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;

- 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 Director of Finance and 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 Director of Finance and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Hosted Bodies – Audit assignments relating to the joint committees will be planned and reported through their specific management structures and then onward to the Hosted Bodies' Audit Committees. The principles set out in appendix A will be adopted for the Hosted Body internal audit work as well.

9.4 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.

12.4 Once every five years, our internal audit provision must be the subject of an External Quality Assessment (EQA). This assessment is required by the PSIAS and was undertaken by The Chartered Institute of Internal Auditors (IIA) in February and March 2018. The EQA report concluded that: "It is our view that NWSSP Audit and Assurance Services conforms to all … 64 fundamental principles … and it is therefore appropriate for NWSSP Audit and Assurance Services to say in reports and other literature that it 'conforms to the IIA's professional standards and to PSIAS.'"

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
April 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 15 working days of receipt of the draft report.	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 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15 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 Chief Executive.
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.

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.

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WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Cwm Taf University Health Board**

Date issued: April 2019

Document reference: 123A2017



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 info.officer@audit.wales.

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Summary report

About this document

1 This document provides the Audit Committee of the Cwm Taf University Health Board (the Health Board) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: Financial audit update

Work area	Progress	Conclusions
Annual UHB Accounts 2018-19	Planning work is underway for the audit of the 2018-19 Health Board accounts (incorporating WHSSC/EASC). Our work is progressing on schedule, and we have brought forward elements of our audit testing where possible to relieve pressure during the final audit visit in April and May. Our Audit Plan (summarising the key details of our financial audit) is presented alongside this update for the Committee's consideration.	Work ongoing.

Performance audit update

Work currently underway or planned

Exhibit 2: Work currently underway or planned

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Review of Temporary Staffing Local Work 2017	Work in relation to temporary staffing usage within the Health Board.	**Draft report being completed**	Joanna Davies	Next Audit committee
Integrated Care Fund (ICF) review	This crosscutting review will involve all public sector bodies. The review will focus on whether the ICF is being effectively managed to deliver integrated and sustainable services to achieve better outcomes for services users. The work will focus at arrangements at both a national and regional level. Fieldwork is anticipated to take place between February and June 2018 to take account of the bid process for the 2018-19 ICF monies.	**Fieldwork complete and locally reported.** **National report due May 2019**		Regional partnership leadership group (October 2018) and Regional Partnership Board (November 2018)
Orthopaedic Services follow-up	This work will examine the progress made in orthopaedic services since our 2015 all Wales review. The 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.	Briefing Stage	John Palmer	October 2019

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
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.	**Draft Report**	Ruth Treharne	Next Audit Committee
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.	**Scoping**	John Palmer	June 2019
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**	Allison Williams Chief executive	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**	TBC	TBC
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	**Not Yet Started**	TBC	TBC

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
	must prepare for the National Assembly by May 2020.			
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.	Not Started	TBC	TBC

NHS Related National Studies and Publications

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

Recent publications / planned publications	
Topic	**Update**
Primary Care out of hours services July 2018	The report shows that despite patients being generally positive about Out of Hours services, those services are under real strain in terms of ability to fill shifts and maintain morale amongst staff. There are also challenges associated with meeting national standards on timeliness, poor quality management information, and integrating the planning of Out of Hours services with other parts of the urgent care system.
Speak my language: Overcoming language and communication barriers in public services April 2018	This report looks at how public bodies, particularly local government and NHS bodies providing front-line services, provide interpretation and translation services for BSL and other languages to enable people facing these communication barriers to access services. We have concluded that organisations varied in the degree to which they understood the needs of their communities and ensured their services were accessible to people needing interpretation and translation services. A summary report is also available.
Well-being of Future Generations – reflecting on Year One May 2018	The report provides an assessment of how public bodies in Wales, including the Health Board, have responded to the Well-being of Future Generations Act. The report found that public bodies are able to give examples of how they have used the Act to make the changes needed for them to effectively apply the sustainable development principle. Public bodies now need to set out how they will continue developing their approach to the Act so that they can deliver on the ambition and maximise the opportunities it affords.
Management of follow up outpatients	This work has considered whether health boards have fully implemented previous audit recommendations for improving the management of follow-up outpatient appointments, particularly in light of the growing numbers of patients who experience delays in receiving their follow-up treatment. Since the publication of the local health board progress update reports, we are bring together the key all-Wales messages, along with findings from supplementary work at a national level, together into a short summary report.
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.
Radiology services in Wales	This report summarises the key messages from our local work on radiology services in Wales Waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed. However, rising demand, difficulties with recruitment and retention of staff, outdated and insufficient scanning equipment, along with IT weaknesses are putting services under pressure and point to the need for clear and targeted action to ensure that radiology services are able to cope with future demand.

Good Practice Exchange

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.

Details of confirmed events, shared learning seminars and webinars can be found on the forthcoming pages on the Wales Audit Office's website.

Event/Product	Details
Working in partnership to combat fraud	We will share investigation techniques, intelligence and the use of data analytics in fraud prevention and detection. This seminar is aimed at all public service officers and members who have counter fraud responsibilities or interests within their organisations including, those: • with responsibility for the organisation's counter fraud strategy eg directors of finance. • with responsibility for undertaking investigative work. • exercising compliance functions which may result in counter fraud action. eg internal auditors. • responsible for assessing applications for services or benefits where there is a significant inherent fraud risk. Public services in Wales are under intense pressure. With funding for services reducing, there is an ever-increasing need for public services to find efficiency savings and eliminate waste. Every pound lost to fraud is a pound wasted. In 2013, the National Fraud Authority estimated that the UK public sector annual fraud loss to be in the region of £6.6 bn (excluding taxation fraud). The Cabinet Office in its recent publication 'Cross-Government Fraud Landscape Annual Report 2018' (opens in new window) estimated that the annual fraud loss for government departments may be anything between £2.7bn and £20.3bn.

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.

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WALES AUDIT OFFICE
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Archwilydd Cyffredinol Cymru
Auditor General for Wales

2019 Audit Plan – **Cwm Taf University Health Board**

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This document has been prepared as part of work performed in accordance with statutory functions. Further information on this is provided in in Appendix 1.

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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.

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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.

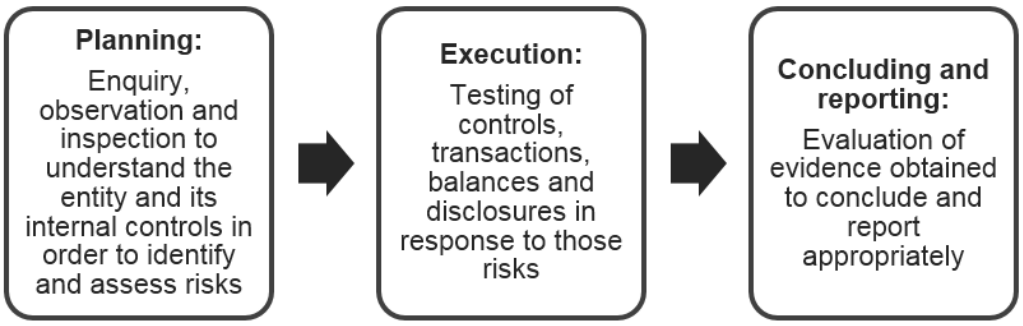
3 There have been no limitations imposed on me in planning the scope of this audit. My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

4 It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them. Appendix 1 sets out my responsibilities in full.

5 The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach



6 The risks of material misstatement which I consider to be significant, and which therefore require special audit consideration, are set out in Exhibit 2 along with the work I intend to undertake to address them.

Exhibit 2: Financial audit risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
Other areas of audit attention	
There is a risk that the Health Board will fail to meet its first financial duty to break even against its aggregate revenue and capital resource limits over a three-year period. The Health Board continues to forecast a break-even position at 31 March 2019. Combined with the small surpluses achieved in 2016-17 and 2017-18, this indicates that the Health Board will meet this financial duty. If the Health Board fails in this financial duty, I will place a substantive report on the financial statements highlighting the failure. The financial pressure on the Health Board increases the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.	My audit team will focus its testing on areas of the financial statements that could contain reporting bias. We will also review with management the Health Board's performance and the impact of all audit findings against the revenue and capital resource limits for the three-year period 2016-17 to 2018-19.

Financial audit risks	Proposed audit response
Other areas of audit attention	
From 1 April 2019, the responsibility for providing healthcare services for people in the Bridgend County Borough Council area will move from Abertawe Bro Morgannwg University Health Board to Cwm Taf University Health Board. Whilst this will not present any direct risks over the transactions within the 2018-19 financial statements, the financial statements will still need to disclose this change from 1 April 2019. Health Board staff face significant additional work from this change, increasing the risk that the Health Board may not produce its 2018-19 financial statements and working papers for audit by the required deadlines.	My audit team will liaise with finance staff to ensure that the accounts production plan is adhered to and appropriate disclosures are made.
The Health Board is participating in a new pooled budget arrangement with Rhondda Cynon Taf CBC and Merthyr Tydfil CBC, called the 'Cwm Taf Care Home Accommodation Pooled Fund'. The total value of this pooled budget for 2018-19 is over £34 million. The Health Board will need to disclose this arrangement and any memorandum accounts accurately in the 2018-19 accounts.	My audit team will review the transactions and disclosures for this new pooled budget in the 2018-19 accounts and ensure that they are materially accurate.
A number of the Health Board's assets under construction have come into operational use during 2018-19. These assets need to be revalued at the time of completion by the District Valuer, with any impairments in book value accurately accounted for.	My audit team will review and test a sample of completed capital projects during 2018-19, to ensure that they have been accounted for in line with District Valuer valuations.
There have been a number of changes to the Independent Membership of the Board and the Executive during 2018-19. These will need to be accurately reflected in the Health Board's remuneration report.	My audit team will review all remuneration report disclosures to ensure that they are accurately and appropriately disclosed.

Financial audit risks	Proposed audit response
Other areas of audit attention	
In 2017-18 we commented to management on several areas during the course of our audit work including the current/non-current classification of clinical negligence provisions and Welsh Risk Pool debtors, and Remuneration report disclosures.	My audit team will follow up on the matters and amendments identified in our 2017-18 Audit of Financial Statements Report as part of our 2018-19 audit work.

7 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

8 For reporting purposes, we will treat any misstatements below a 'trivial' level (set at 5% of materiality) as not requiring consideration by those charged with governance and therefore we will not report them.

9 My fees and planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided in accordance with the agreed timescales, to the quality expected and have been subject to a robust quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

10 I am also responsible for the audit of Cwm Taf University Health Board's (the Board) charitable funds accounts. The audit will be undertaken in accordance with the timescales agreed with the Board and the Charity Commission. My audit fee for this work is included in Exhibit 4.

[1] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.

Performance audit

11 It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

12 I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as 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].

13 The topics I plan to examine as part of my 2019 performance audit work are summarised in Exhibit 3.

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 approaches to quality governance across NHS bodies. I will also consider the local work that has already been undertaken in the Health Board to review the quality governance arrangements as part of my 2018 audit plan.

[2] An operational protocol between HIW and the Auditor General sets out how the two organisations will work together. March 2015.

[3] Wales Audit Office, **Working Together to Provide Assurance describes the collective arrangements the AGW and HIW make use of to review governance arrangements in the NHS**, November 2016.

Theme	Approach/key areas of focus
All Wales Thematic Reviews	**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 wellbeing objectives in more detail, reviewing the steps that have been taken to achieve that objective. When selecting which wellbeing objectives to review, I will aim to do so in such a way that maximises my ability to compare 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/other committee.
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

14 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

15 Your estimated fee for 2019 is set out in Exhibit 4. There have been some small changes to my fee 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 1.2% decrease compared to the fee set out in the 2018 annual audit plan.

Exhibit 4: audit fee

Audit area	Proposed fee for 2019 (£)[4]	Actual fee for 2018 (£)
Financial accounts work	**245,822**	**250,822**
Performance audit work	**157,171**	**157,171**
• Structured Assessment	73,210	65,925
• All-Wales thematic reviews[5]	64,970	66,231
• Local projects	18,990	25,014
Total fee	**402,993**	**407,993**

16 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.

17 Further information on my fee scales and fee setting can be found on our website.

Audit team

18 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
Derwyn Owen	Financial Audit Engagement Lead	02920 320651	derwyn.owen@audit.wales
Dave Thomas*	Performance Audit Engagement Lead	02920 320604	dave.thomas@audit.wales
Gareth Lucey	Financial Audit Manager	02920 829398	gareth.lucey@audit.wales
Sara Utley	Performance Audit Lead	02920 829399	sara.utley@audit.wales
Steve Stark	Financial Audit Team Leader	02920 829347	steve.stark@audit.wales

* Engagement Director for the Health Board.

[4] The fees shown in this document are exclusive of VAT, which is no longer charged.

[5] As detailed in the respective audit plans.

19 I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention.

Timetable

20 I will provide reports, or other outputs as agreed, to the Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 6.

Exhibit 6: timetable

Planned output	Work undertaken	Report finalised
2019 Audit Plan	January 2019	February 2019
Financial accounts work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum	January to June 2019	May 2019 June 2019 July 2019
Performance work: • Structured Assessment • Governance arrangements underpinning quality and safety committees • Implementing the Well-being of Future Generations Act • Local project work	Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study.	
Annual Audit Report for 2019	December 2019	December 2019
2020 Audit Plan	December 2019 to January 2020	February/March 2020

Future developments to my audit work

21 Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS), 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
Locum Doctor Review	Draft report	Draft report planned for March 2019.
Clinical Coding Follow-up	Draft report	Draft report planned for March 2019.
Orthopaedic Services Follow-up	Set up	Fieldwork due to commence in spring 2019. Draft report planned for September 2019.

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 the 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.

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

[6] www.audit.wales/news/no-deal-brexit-planning-being-ramped-picture-varies-across-wales-public-services

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Auditor General for Wales

Structured Assessment 2018 – **Cwm Taf University Health Board**

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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.

The team who delivered the work comprised Sara Utley, Gareth Lucey, Urvisha Perez, Gareth Lewis, and Steve Stark under the direction of Dave Thomas.

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About this report

1 This report sets out the findings from the Auditor General's 2018 structured assessment work at Cwm Taf 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, committee and management 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. Fifteen of the 22 (68%) board members invited to take part at the Health Board responded.

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. Appendix 2 sets out the Health Board's response to the recommendations arising from our 2018 work.

Background

5 Our 2017 Structured Assessment work found that the Health Board's governance arrangements and those for financial planning and management continued to operate effectively. We also identified opportunities to improve change management arrangements, progress reports against the strategic plan and ongoing issues with workforce management and implementation of the digital strategy.

6 During 2017-18, the Health Board remained on routine monitoring under the NHS Wales Escalation and Intervention Framework. It once again achieved a break-even financial position, reporting a £63,000 cumulative surplus for the years 2015-16 to 2017-18. The Health Board developed the Integrated Medium Term Plan (IMTP) for 2018-2021 within the timeframe required by the Welsh Government and it received approval from the Cabinet Secretary for Health and Social Services.

7 Over the past 12 months, there have been changes amongst the Executive team and most recently the Director of Nursing retired. The Health Board has put interim arrangements in place until a new Director of Nursing is appointed in 2019. Last year the Health Board experienced significant Independent Member turnaround similar to other Health Boards; five members left including the chair and the vice chair. The Health Board has managed this change well.

8 The most significant change to affect the Health Board this year is the Welsh Government's decision to expand the Health Board's boundaries to include the population of the Bridgend County Borough Council (BCBC) area. This means that healthcare services currently provided by Abertawe Bro Morgannwg University Health Board across the BCBC area will transfer to the Health Board from

1 April 2019. The Health Board will also need to forge new partnerships with BCBC particularly around the integration of health and social care.

9 For the purposes of this year's Structured Assessment, we did not review the Health Board's arrangements for the transfer of services and boundary changes. A Joint Transition Board has been established to manage the transfer of services between Abertawe Bro Morgannwg University Health Board and the Health Board. Membership of the Joint Transition Board includes the Chairs and Chief Executives of both the Health Board and Abertawe Bro Morgannwg University Health Board and a newly appointed programme director. Structures to support the Joint Transition Board have been established, including a Joint Transition Programme Group, which is underpinned by various workstreams. The Joint Transition Board reports to both health boards' executive teams through their respective Chief Executives and then subsequently to their respective Boards.

Main conclusion

10 This year's Structured Assessment work has demonstrated that **while the Health Board has good strategic planning and financial management arrangements, it continues to have significant workforce challenges and its quality governance arrangements require improvement**.

11 The findings which underpin these conclusions are considered in more detail in the following sections.

Governance

12 As in previous years, our Structured Assessment work examines 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 sub 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.

13 We found that **the Board continues to operate well, however, aspects of quality governance, risk management and oversight of ICT arrangements do require improvement**.

Conducting business effectively

14 We looked at how the Board organises itself to support the effective conduct of business. We found that the Board is operating effectively, but the Quality, Safety and Risk Committee is not as effective as it could be, and there are gaps in the arrangements to oversee progress on ICT developments.

15 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' that ensures that key aspects of business are covered in the agenda. The administration of Board meetings is good, and it is clear when decisions are made and recorded. The Board and committees undertake annual self-assessments which provide opportunities to review their effectiveness. We continue to observe good levels of scrutiny and challenge with generally good responses from executive at board and committee meetings including Finance Performance and Workforce (FPW) and the Audit Committee, particular credit is given to the

work of the FPW committee into their deep dives into directorates and holding to account for performance as well as their review of the operation of directorates including scrutiny of the challenges they are facing. The Health Board operates an integrated governance committee (IGC), made up of the Chairs of all the Board's committees. The IGC maintains oversight of the work of the board sub committees. It ensures integration of the governance work to ensure that issues do not fall outside or between the work of the sub committees, minimises duplication and co-ordinating issues which need the attention of more than one of the Board's sub committees. The work of the Integrated Governance Committee is good and gives an opportunity for issues to be cross referred and discussed amongst committee chairs.

16 As part of this year's structured assessment, we asked board members about the conduct of board meetings. Our survey found that:

- 87% of board members responding felt that the agenda was a manageable length compared with 74% of board members across Wales;
- 87% of board members responding felt there was always or mostly sufficient time to consider all agenda items compared with 71% of board members across Wales; and
- 87% of board members responding felt that the agenda was always or mostly organised so that the important items appear first compared with 58% of board members across Wales.

17 Our survey sought board members' views about whether the information needed for effective oversight and scrutiny had been agreed and the level of confidence in the information they received. Most (93%) board members responding to our survey indicated that the Board had agreed the information it needed compared with 79% across Wales. Board members were generally confident in the quality and accuracy of the information received and that it was sufficient to inform decision making and to support effective scrutiny. Our observations of committee meetings show that Independent Members are confident in suggesting improvements to the presentation of information.

18 Last year we noted the challenges for the secretariat in producing committee papers one calendar week before meetings. The secretariat continues to work hard to ensure papers are available in the required timeframe. There have been examples where papers were not ready in time, but the committees have dealt with this appropriately.

19 Over the last year there has been significant turnover amongst the Health Board's Independent Member (IM) cadre with five IMs including the chair and vice chair of the Health Board coming to the end of their tenure. These were replaced by new members. The Health Board has managed this process well putting in place bespoke training and wrap around support for the new cohort of IMs who joined the Board. The findings from our board member survey show that IMs were satisfied with the training and support that they receive. In particular:

- all IMs responding were satisfied or very satisfied with the induction programme for new Board members compared with 65% of IMs across Wales;
- all IMs responding were satisfied or very satisfied with the training and support provided to them to discharge their responsibilities compared with 83% of IMs across Wales; and
- all IMs responding were satisfied or very satisfied with the programme of board development to support effective board working compared with 85% of IMs across Wales.

20 Board member walkabouts and ward visits have been in abeyance recently due to board level turnover, and the framework supporting these visits needs to be updated to reflect the recent IM

changes. All IMs responding to our survey were satisfied or very satisfied with the opportunities to meet staff and visit wards compared with 65% of IMs across Wales.

21 The Quality, Safety and Risk (QSR) Committee uses patient stories and this year has looked at three patient stories in relation to A&E and community pharmacy as well as clinical ethics. The Health Board provides support for patients to tell their story. However, papers presented to the QSR Committee are not yet succinct and meeting agendas are not prioritised. We are aware that the Health Board is also undertaking a review of the sub committees reporting into the QSR committee as this is an area that requires improvement. This year we also identified the following issues:

- during 2017-18, the QSR Committee approved 41 policies. Given the busy agenda it would be better to map policy renewals to assess whether some policies could be approved by an alternative committee or group, leaving valuable time for scrutiny.
- due to the IM tenure ending the committee had a vacancy for one IM on the committee for a significant part of the year.
- the information presented to the QSR Committee does not always highlight areas of concern at the front of reports and instead relies on the reader finding it within the report. There is little information on the remedial actions to address poor performance, and lessons learned could be better highlighted.

22 Last year the Health Board developed its Digital Health Strategy and it established the Digital Health Strategy Steering Group to oversee delivery of the strategy. The steering group's terms of reference state that it will align and work closely with the work of the Information Governance Group and provide regular assurance reports to the QSR Committee. Our review of the QSR Committee papers found no evidence that the Committee has received assurance reports from the steering group. Consequently, it is unclear how the Board receives assurance on progress with implementation of the Digital Health Strategy.

23 The Scheme of Delegation, Standing Orders and Standing Financial Instructions are up to date and reviewed regularly. However, the Health Board needs to update their Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to delegate responsibility for calculating nurse staffing levels to a senior registered nurse, usually the Executive Director of Nursing.

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 despite a board assurance framework and risk management strategy being in place there is a need to improve the operational identification, review and mitigation of risk.

25 The Health Board has an established Board Assurance Framework (BAF) clearly linked to the Integrated Medium Term Plan. The Board undertakes an annual review of the BAF, which is publicly available. The BAF outlines the principle risks threating the delivery of the Health Board's strategic objectives. It aligns the principle risks, key controls, risk appetite and sources of assurance against each strategic objective. The Health Board plans to further strengthen board awareness by providing training on risk and risk appetite for the Board before the next review of the BAF when the IMTP is refreshed.

26 Compilation of the BAF relies on robust risk management arrangements within the organisation to identify, review and update risks. The Health Board has an approved risk management strategy. The

risk management strategy notes that directorate managers will monitor and develop mitigating actions to control risks. The strategy also requires regular reviews of risk registers by integrated governance groups at directorate level to escalate risks where risks cannot be managed by the directorates to the executive team and then to Board. Executive directors then have a directorate risk profile and there is a process to escalate to the organisational wide risk register. Positively, each risk on the corporate risk register can be tracked back to the original risk assessment. The corporate risk register is received and reviewed by the executives, Board as well as the Quality, Safety and Risk committee regularly.

27 As part of this year's structured assessment, we asked board members about risk management. The findings from our survey show that board members are overall happy with the arrangements in place for identifying and managing risks:

- all board members responding to our survey understand the risks to achieving strategic objectives and how they are being managed;
- most board members (86%) felt they were involved in identifying risks to achieving strategic objectives compared to 91% across Wales;
- most board members (93%) felt that the information presented to the Board allows members to effectively scrutinise actions being taken to mitigate risks compared to 77% across Wales; and
- most board members (93%) responding were clear on how risks were both managed and escalated up to the Board or committees compared with 86% across Wales.

28 Although it is positive that board members are overall happy with risk management arrangements, recent work undertaken by the Internal Audit service in some directorates and our review of the estates risk register indicate potential to improve timeliness of risk reviews and associated actions to mitigate risks. Directorates are meant to review their risk registers at their routine clinical business meetings. However, this does not appear to have been happening consistently and therefore some risk registers are out of date. This could mean that the organisational risks currently on the BAF are not reflective of the current issues facing directorate teams.

29 Staff receive corporate training to assist them in completing risk registers, which includes identifying, managing and mitigating risks, and written guides are available on SharePoint.

Embedding a sound system of assurance

30 We also examined whether the Health Board has an effective system of internal control to support board assurance. We found that important aspects of the Health Board's quality governance arrangements require improvement and the Health Board needs to address information governance plans and capacity.

Performance management and monitoring

31 There are a range of activities in place to monitor performance within the Health Board, these include;

- Clinical business meetings – where a small core of executives meet on a monthly basis with clinical and managerial leads of each directorate to provide oversight and performance management of the entire operation;
- Corporate business meetings (CBM) – where a small core of executives meet on a bi-monthly basis with the managerial leads for each major corporate function to provide oversight and performance management; and
- Efficiency, Productivity and Value Board (EPV) – where the Chief Executive oversees the cluster of cross-cutting themes and associated activities to achieve medium to long-term improvement trajectories.

32 The Health Board produces a comprehensive Integrated Performance Dashboard linked to the NHS Wales Delivery Framework and Tier 1 targets. The dashboard contains relevant benchmarking, trends and forecasting, and supporting narrative provided for areas where performance needs to improve, eg performance against A&E targets. The indicators are grouped into the Health and Care Standards themes. Trend data shows performance over the preceding 12 months with a summary of performance and the action being taken to address areas of underperformance. The information is very detailed and enables scrutiny, and the Health Board continues to refine the presentation of this information.

33 Our survey sought board members' views on the information they receive to help them discharge their role. Overall, Board Members were positive about the information they received over several domains including operational delivery and service quality. We found that most board members (92%) felt that the board had agreed the information it needed for effective oversight and scrutiny compared to 79% across Wales. Overall, most board members (86%) felt that they had a good understanding about how well the organisation was performing in relation to service quality compared to 80% across Wales and (80%) felt that they had a good understanding of how the organisation performs in relation to patient experience compared to 64% across Wales.

Quality governance

34 Whilst the Health Board appears to have the necessary structures and processes in place to support quality governance, in practice we are concerned that the system is not effective in highlighting issues and concerns or demonstrating responses to improvements.

35 The Quality Strategy and the Quality Delivery Plan is designed, implemented and monitored by the Quality Steering Group (QSG), which reports to the Quality Safety and Risk Committee. The QSG collates information from several sub-groups, such as the concerns panels which consider complaints, redress, patient safety and incidents. The QSG is responsible for the preparation of the Quality Report received quarterly by the Quality, Safety and Risk Committee.

36 However, the QSG has not met as regularly as required, and reports of its activity have to the Quality Safety and Risk Committee have been infrequent and not compliant with the terms of reference.

37 Our review of the Quality Report found that the information presented does not enable readers to easily identify areas of concern. Summaries of the quality report do not effectively highlight where the

Committee's attention should be drawn and why. For example, there was a 9% increase in falls reported between May 2017 and June 2018, but the Quality Report does not identify what actions are being taken to address this issue. The information on patient experience and learning from concerns is also presented in the Quality Report but it is difficult to identify the directorates where concerns arise. This makes it difficult to triangulate information across a range of quality and safety measures. In general, the Quality Report could be more effective at highlighting where lessons have been learnt and changes have consequently been made.

38 The Health Board first produced a Quality Strategy covering the period 2015-2017. After considering the implications of the Bridgend boundary change a decision was made to hold off producing a full quality strategy until the transition of services has been delivered, and instead to produce an interim Quality Strategy covering one year.

39 The Health Board aims to revise the Quality Strategy following the transfer of services from Abertawe Bro Morgannwg University Health Board. We have noted that the interim Quality Strategy provides no assessment of the current state of quality within the Health Board nor makes it clear what progress they would want to see by when.

40 Arrangements for staff to raise concerns need strengthening. The Board survey respondents felt that, in the main, the organisation has a track record in actively encouraging staff to identify and report concerns and complaints and ensure that it listens and responds not only to good news stories but also to feedback on poor quality care. However, a recent Internal Audit review reported in October 2018 gave limited assurance in relation to arrangements for raising concerns (Whistleblowing). The review raised concerns around how the Health Board had communicated the raising concern policy to employees, it was not part of the induction for new employees and there had not been any recent training nor a comprehensive awareness campaign. The review also highlighted that policies and procedures were available on the intranet but the Health Board was unable to demonstrate how it communicated these to staff who do not routinely have access to IT. Additionally, more support was needed for line managers to support them in managing staff concerns and there was a requirement for a central log of concerns to enable analysis of this data to be undertaken. Positively results from the NHS staff survey do show that 93% of respondents (22% overall response rate which was below the average) said that the last time that they saw an error, near miss, or incident, that could have caused harm to staff, they reported it. A positive culture of incident reporting is to be recognised.

41 Issues with serious incident reporting within maternity have recently come to light. An independent review by the Royal College of Obstetricians and Gynaecologists was initially agreed to be commissioned by the Health Board. This has now been commissioned directly by the Cabinet Secretary for Health and Social Services and is due for completion by the end of spring 2019.In the interim, it is important that the Health Board demonstrates organisational learning and seeks assurance that issues uncovered in maternity services are not more widespread.

Clinical Audit

42 The Health Board has a clinical audit plan for 2018-19 in place. The plan identifies the clinical audit projects that that the Health Board must participate in nationally, as well as the local audits which have been identified through clinical priorities and patient and public experience initiatives. The plan also includes priorities from the quality strategy and the quality delivery plan.

43 The Health Board's strategy for clinical audit had previously been included within the Health Board's 2014-2017 Quality Strategy. However, a review by Internal Audit in January 2018 recommended that the Health Board produce a stand-alone plan for clinical audit, as coverage in the Quality Strategy was not sufficiently detailed. It is therefore an improvement that the Health Board presented a stand-alone document separate from the Quality Plan to the Audit Committee in July 2018.

44 Compliance with the Clinical audit plan is reviewed and monitored on a quarterly basis through the clinical audit and quality improvement operational group and the quality steering group. The Audit Committee and the Quality, Safety and Risk Committee both have responsibilities for clinical audit, which are;

- Audit Committee – that the Health Board has a visible clinical audit programme in place and the outcomes provide internal assurance to the board; and
- Quality Safety and Risk Committee – ensure arrangements are in place to undertake, review and act on clinical audit activity which responds to national and local priorities

45 The mechanism in place for monitoring performance of clinical audit for the Quality Safety and Risk Committee is through the Quality Report. However, there is a lack of detail; recently it was found that national audits were not being completed as required within maternity due to capacity issues. The clinical audit team have recently provided all directorates with an update of their progress against their audit plans.

Information governance and information security

46 Work has been ongoing to strengthen the Health Board's arrangements in relation to the General Data Protection Regulation (GDPR) requirements. There is an Information Governance Management Framework in place, which is supported by key policies. However, the Health Board needs to update its framework following the recent adoption of all-Wales policies on information governance and information security and reflect the change in Data Protection Officer. An Information Governance Group is in place and it reports to the QSR Committee. The Chair of the Information Governance Group, who is an IM, is stepping down when his tenure ends in December 2018, which will leave an IM&T champion gap at Board level. The Health Board is achieving its Freedom of Information request targets and the Health Board has recently recruited additional staff to the team, but impending boundary changes may require more resources in future. Compliance with information governance training has improved since last year and is currently 69.8%, but well below the 95% national target.

47 There is no cyber security action plan in place. In March 2018, the Health Board received the findings of an external cybersecurity assessment, which identified significant improvement actions needed to strengthen arrangements. The report highlighted the lack of cyber security personnel as the Health Board has only one Information Security Manager and no dedicated support staff, which limits the time available to provide suitable support and advice. The Information Security Manager has previously been unsuccessful when requesting additional cyber security staff and is currently waiting for a decision on a recent request to the Executive Management Board. The executive team are aware of the need for further staff in this area, and it has formed part of IMTP planning discussions, and further work is expected in the next planning cycle to enable additional resources to be allocated. The report also highlighted evidence of the existence of old and unsupported versions of software, and a significant number of instances indicating a failure or lack of up-to-date security patching of Microsoft Operating Systems. A clutch of third party-maintained imaging servers also showed poor patch

management. The Health Board needs to ensure that it addresses the issues identified in the report and develops an action plan, to minimise any associated risks (for example, a successful cyber-attack) as much as possible and progress is monitored through the Information Governance Group.

National Fraud Initiative

48 Last year, we reported that the Health Board did not review the recommended data matches from the National Fraud Initiative (NFI) biennial data-matching exercise in a timely way. In January 2017, the Health Board received 5,263 data-matches as part of the most recent biennial exercise. The data-matches highlight anomalies which when reviewed can help to identify fraud and error. Whilst we would not expect participants to review all data-matches, some of the matches are categorised as 'recommended matches'. These are matches considered to be of high risk and therefore recommended to be prioritised. The Health Board received 311 recommended matches. In our 2016-17 Annual Audit Report, we reported that as at 20 November 2017 the Health Board had only reviewed nine data matches and had failed to make effective use of NFI as part of its arrangements to prevent and detect fraud. As at 12 November 2018, the NFI web application records that the Health Board has now reviewed 216 data matches. Whilst we acknowledge that the Health Board has made progress, it still has a number of recommended matches that need reviewing. It is essential that these data-matches are reviewed as a matter of urgency. These matches include matches between payroll, creditor payments and Companies House data and matches between staff and supplier bank accounts.

Tracking recommendations

49 During 2018, the Health Board made changes to the audit tracker, which is presented at each meeting of the Audit Committee. Progress against recommendations is considered at every meeting with the pace of progress often challenged. At times, the Committee invites officers to prepare and present more detailed reports when action to address the recommendations is taking longer than anticipated and where audit reports have provided limited assurance. A cover report now accompanies the tracking log to give an overview to the committee of the position in respect of recommendations.

50 However, recommendations marked as complete are removed with little commentary to evidence removal of the recommendation. There is also an opportunity to utilise the tracker to co-ordinate actions in response to recommendations from other inspections and external reviews, such as Healthcare Inspectorate Wales, Ombudsman reports and Delivery Unit Reports. This approach would give the tracker wider applicability and could provide useful information to assist the work of the Quality, Safety and Risk Committee.

Ensuring organisational design supports effective governance

51 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 the Health Board has clear executive portfolios and lines of accountability, but clinical business meetings need more focus on quality and safety.

52 Arrangements for executive portfolios are clear, there is a clear organisational structure in place which sets out the roles and responsibilities. The Health Board has not made significant changes to its

overall operational structure since our last review. However, during 2018, there have been several changes amongst the Executive Management Team.

53 There are short to medium-term arrangements in place to manage changes to appointments amongst the executive team with the exception of the Board level role for the Director of Therapies and Health Sciences which is currently vacant. However, the Chief Operating Officer, who is also the Director of Therapies and Health Sciences, is currently seconded to Abertawe Bro Morgannwg University Health Board and he is available for advice should the assistant director of therapies and health sciences require support. Interim arrangements are in place with the Director of Primary and Community Mental Health moving into the Chief Operating Officer role, while a new Director of Primary Community and Mental Health was appointed. The Director of Nursing, Midwifery and Patient Care retired recently, and interim arrangements are in place until the appointment of a new director in 2019. The Director of Finance was appointed earlier this year having previously worked for the Health Board.

54 As mentioned previously in this report the Health Board has a mechanism of Clinical Business Meetings (CBMs), where a small core of executives meet on a monthly basis with clinical and managerial leads of each directorate to provide oversight and performance management. The Health Board sees these meetings as the mechanism to improve directorate performance against key performance indicators and improve service safety and service quality for patients and staff. In 2016, we recommended that the Health Board agree a consistent approach and terms of reference for Clinical Business Meetings as this had been highlighted in an Internal Audit Review. However, while there is a draft Terms of Reference for these meetings we have been unable to see a final version. From our review of minutes, we feel further work is needed to ensure quality and safety are discussed on a par with performance. Interviews within the executive management team have indicated that the ways the CBMs operate in the future are expected to change.

55 We have recently been made aware that the Health Board is reviewing the underpinning clinical governance structures and framework that underpin the directorate level arrangements. The new structure currently being developed aims to simplify the directorate and localities structures.

56 As the work progresses with the boundary change, the Health Board may need to reflect on executive portfolios and additional capacity requirements.

Strategic planning

57 Our work examined how the Board sets strategic objectives for the organisation. We assessed how well the Health Board plans how it will achieve its objectives, using funding, people and other resources that it has, or can make available. We wanted to know how the Health Board develops its strategic plans and how directorates are supported internally. Finally, we wanted to know if the Health Board is monitoring progress with these plans effectively.

58 We found that **the Health Board has good arrangements for strategic planning, and effective support for directorates but tracking progress is difficult without detailed IMTP milestones**.

Setting the strategic direction

59 We looked at how the Board goes about setting its priorities in engagement with key stakeholders and setting them out in a clear IMTP. We found that the Health Board has a clear strategic vision and is developing its long-term clinical services strategy.

60 There is a clear strategic vision for the organisation and most board members (93%) responding to our survey reported that they were always or mostly involved in setting the vision and strategic priorities. The Health Board's central philosophy is Cwm Taf Cares. The 2018-2021 strategic priorities are grouped around five care themes and set out in the Health Board's IMTP. These care themes are:

- Wellbeing Self Care and Supported Care
- Integrated community care
- Care closer to home
- Acute care
- Tertiary services

61 Within these themes the Health Board has articulated three-year outcomes as well as priorities for 2018-19 – 2020-21. There are 16 priorities detailed over a wide range of areas and each of these has a 'plan on a page' for its achievement. The priorities are ambitious and build on successes from previous years, for example the Stay well @ Home service.

62 In addition to the care themes, there is an overarching enabler theme, which includes achieving financial balance, further developing leadership and delivery capacity and managing recruitment and retention amongst other areas.

63 The Health Board has a detailed engagement plan for consultation with key internal and external stakeholders on Health Board priorities. The strategic priorities set out in the IMTP were informed by effective engagement with key stakeholders both internally and externally. The IMTP engagement plan ensures that all the Health Board priorities are informed and influenced by those who have an interest in them. The groups range from Executive Board and the Board to Medical Leadership Forums and Strategic Partnership Boards and public fora.

64 This year the Health Board has been developing its long-term Clinical Services Strategy, but development was paused until the outcome of the consultation on boundary changes was known. The Health Board has indicated it has resumed its development and expects to publish before the end of 2018.

Developing strategic plans

65 We considered the Health Board's approach to developing the strategic plan. We found that the Health Board has a well-developed approach to its strategic planning underpinned by demand and capacity modelling and guidance.

66 The Health Board's approach to developing its IMTP remains consistent and builds upon the preceding plan. The Health Board has developed the IMTP within the required timeframe for the fifth consecutive year. In January 2018, the Board approved the draft IMTP, having reviewed and influenced the emerging draft through board development sessions and public board meetings.

67 Underpinning the IMTP is a series of plans that cover a range of cross-cutting themes, such as increasing workforce productivity and embedding the principles of prudent healthcare. The Health Board prepares annual guidance, which it launches at an organisation-wide planning workshop. The guidance sets out the local planning requirements and key milestones. As part of the IMTP planning process, the Performance and Information Department prepares skeleton demand and capacity plans for each directorate and locality with respective managers updating them. In March 2018, the Internal

Audit service reviewed the arrangements and highlighted concerns regarding lack of support for directorates, lack of clinical engagement and directorates not using demand and capacity plans to manage the business. The recent update report by Internal Audit has shown improvement, with improved clinical engagement and increased management oversight. The Health Board needs to be mindful of these areas when moving into the next IMTP planning round. Progress in developing the local IMTP plans is monitored by the Health Board's Integrated Planning Group and works well.

68 Last year, capacity within the Programme Management Office (PMO) was limited, which risked affecting the Health Board's ability to implement change. Additional support has been allocated to the PMO team to support work on the Bridgend transition. This is on a non-recurrent basis, and the Health Board is keeping this area under review with a view to growing its sustainable project management capacity to achieve its service transformation ambitions.

69 At the time of our audit work, the Health Board was preparing the next iteration of the IMTP, which will need to reflect the boundary changes and the wider integration of services following the transfer from Abertawe Bro Morgannwg University Health Board. The Health Board is developing processes to manage the transfer and integration of services and is currently engaged with them in developing their IMTP plans for next year. Information presented to Board highlights the Health Board approach to including Bridgend in the planning arrangements, and they are being engaged through the planning workshops and regular meetings with Cwm Taf.

70 The Health Board's IMTP contains several annexes, including details on financial strategies as well as workforce and organisational development. The IMTP provides a snapshot of the workforce with workforce assumptions set out, namely annual turnover and increase in salary costs. The IMTP does highlight workforce challenges such as reliance on agency and locum staff as well as areas within the Health Board where there are recruitment difficulties such as estates, maternity and primary care. Directorate IMTPs contain workforce plans and monitoring of these is through the clinical business meeting process.

71 Our board member survey found that, overall, board members who responded were happy that the clinical strategy, workforce plan and capital plan were effectively underpinning the delivery of the organisational objectives. The annexes to the IMTP also set out the Health Boards approach to prudent healthcare delivered through a cross-cutting theme managed by the EPV Board.

Monitoring delivery of the strategic plan

72 Finally, we looked at whether delivery of strategic plans is effectively monitored. We found that the Health Board has processes for monitoring delivery of the IMTP but without detailed milestones it is challenging to gain an accurate impression of progress.

73 Arrangements are in place to monitor and report on delivery of the IMTP. The Board receives a quarterly performance report against the five care themes within the IMTP and an annual summary of progress in the subsequent IMTP. However, the way the IMTP is set out makes it difficult to track milestones.

74 In 2017, we recommended that the Health Board refine the IMTP reporting process to include detailed information on milestones to enable Independent Members to understand progress against the expected trajectory. IMTP reporting has improved since our last Structured Assessment and the link to activities and the strategic themes of the Health Board are clearer, but without a clear picture of the

milestones in the IMTP it is difficult for an external audience to identify progress and see whether the IMTP priorities are on track.

75 Last year we reported on a new executive level board to provide oversight of the cross-cutting themes within the IMTP. The EPV Board first met in June 2017 partly in response to issues with the visibility of work on the cross-cutting themes. Board assurance is received through the Finance, Performance and Workforce Committee.

76 Board members reported they were happy with the information they received on the strategic change programme and IMTP performance reports. Our Board member survey found that;

- 86% of board members responding to our survey agreed that the information they received around strategic change programme delivery gave them a good understanding of the Health Board's performance compared with 83% across Wales; and
- all board members responding to the survey agreed that the information they received gave them a good understanding of the Health Board's performance in relation to IMTP delivery compared with 90% across Wales.

Wider arrangements that support the efficient, effective and economical use of resources

77 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 examine if the Health Board is procuring goods and services well.

78 We found that, overall, **financial and asset management arrangements are sound, and the Health Board performs comparatively well on several key performance targets. However, there is a need for continued action to address several significant workforce challenges, including factors driving the relatively high use of locum and agency staff**.

Managing the workforce

79 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. Within Wales there are significant workforce challenges which are being faced by Health Boards. Within Cwm Taf UHB we found that Workforce issues continue to challenge the Health Board, but it is taking steps to tackle issues such as higher-than-average agency expenditure and turnover rates.

80 The following table shows how the Health Board is performing in relation to some key measures compared with the Wales average. Exhibit 1 shows that the Health Board's performance is the same or broadly comparable to the Wales average for sickness absence, vacancy rates and compliance with statutory and mandatory training. Turnover is higher than the Wales average, while compliance with the appraisal process is much better.

Exhibit 1: performance against key workforce measures July 2018[1]

Workforce measures	Health Board	Wales average
Sickness absence	5.6%	5.3%
Turnover	9.0%	6.9%
Vacancy	2.6%	2.6%
Appraisals	76%	67%
Statutory and mandatory training	74%	73%

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018.

81 The Health Board's IMTP (2018-2021) highlights the biggest challenge to the Health Board's financial position is the overspend on medical, dental and nursing locums, and bank and agency expenditure. At July 2018, the Health Board's agency spend was 6% of their total pay bill, which is the second highest proportion in Wales. Agency spend is particularly high for medical and dental staff and accounts for 15% of the medical and dental pay bill while nursing and midwifery agency costs account for 6% of the pay bill. Since July 2017, there has been a small reduction (1.6%) in agency spend on medical and dental staff and an even smaller reduction (0.5%) on nursing and midwifery staff. Spend on agency allied health professionals has seen the biggest reduction since last year (8.7%). The Health Board recognises the need to reduce agency spend.

82 Workforce productivity is one of the Health Board's cross-cutting themes, which aims to reduce medical, dental and nursing and midwifery agency spend by approximately £5.1 million by next year (2018-19) through initiatives such as 'retire and return' for nurses and introducing e-rostering and e-job planning for the medical workforce. The cross-cutting programmes are overseen by the EPV Board, which is chaired by the chief executive.

83 There are several factors affecting recruitment and retention, such as an aging workforce, changes to pension and tax legislation and recruitment to training places, and these factors affect certain staff groups more than others. Exhibit 1 shows the Health Board has a higher-than-average turnover rate. As at July 2018, turnover amongst nursing and midwifery staff and allied health professionals was the highest in Wales at 10% and 9.6% respectively (the Wales average was 7.3% and 7.9% respectively). Compared to July 2017, the number of advertised vacancies for both staffing groups has seen little or no change. The Health Board's IMTP cites recruitment and retention as two of the key workforce challenges and poses a significant risk to delivering safe and effective services. The Health Board has cited difficulties recruiting medical staff in some specialities, such as consultants in acute medicine, accident and emergency, pathology, urology and general practitioners. In addition, nursing recruitment is a challenge, especially in the areas of acute medicine and maternity, both within Prince Charles

[1] Sickness: rolling 12-month average at July 2018; Turnover: 12-month period July 2017 to June 2018; Vacancy: one month at July 2018; Appraisal: preceding 12 months at July 2018; Statutory and mandatory training: at July 2018.

Hospital and Royal Glamorgan Hospital. There are other recruitment difficulties such as for imaging specialists, pharmacists and allied health professionals.

84 The Health Board is taking a number of actions to help fill vacancies, for example, recruiting nurses from abroad and running recruitment campaigns such as the national '#joincwmtaf.wales' campaign. The Health Board's IMTP states that the '#joincwmtaf.wales' campaign has resulted in an increase in its graduate and general nursing adverts. The Health Board also commissioned a PR company to develop a campaign that will initially focus on recruiting medical, and allied health professionals. This campaign aims to dovetail with the national 'TrainWorkLive' campaign. For certain staff groups, such as nursing, recruitment is relatively successful, but retention is poor. In response to this the Health Board is developing a nursing retention strategy.

85 Given the challenge, recruitment and retention are only part of the solution. The Health Board needs to modernise its workforce and use staff differently. The Health Board is implementing several workforce redesign programmes. The Health Board's key workforce modernisation priorities for 2018-2021 are:

- further development of advanced and extended clinical roles within secondary and primary care;
- trialling and introducing alternative practitioners, such as physician associates; and
- development of the healthcare support worker role within secondary and primary care.

86 In April 2018, the Health Board ran a workshop to showcase new roles and because of the workshop's success, it is establishing an executive level modernisation board. Whilst some service areas still recruit like for like, the Health Board reported that this practice is slowly changing, but more needs to be done. The Health Board is increasingly taking a bottom-up look at roles, to understand what types of roles services need.

87 The Health Board has one of the highest sickness absence rates when compared to other health boards and the Wales average. At July 2018, the rolling 12-month sickness absence rate was 5.6% and is the third highest when compared to other health boards (range 4.1% to 7.3%) and the Wales average (5.3%). Sickness absence rates are above average for all staff groups except for professional scientific and technical staff and allied health professionals. The Health Board's corporate risk register rates 'failure to achieve the management of absence target' as high. The Health Board reported a tailored approach to managing sickness absence. Sickness absence data is scrutinised at monthly CMB meetings, then followed up with work tailored to each directorate's needs. The Health Board has set a target of reducing sickness absence levels to 4.7% by the end of 2021. Given the issues with recruitment, retention and agency expenditure we would question whether this target is ambitious enough. The Health Board reported that they have a programme of staff wellbeing activities, and following reassessment in February 2018 have been awarded Platinum for the Corporate Health Standard.

88 The Health Board does not have a training and development plan and has not undertaken a training needs assessment. However, the IMTP states that the Health Board will be finalising and implementing three core organisational development frameworks supporting engagement, education and leadership. The frameworks and the associated workstreams are at various stages of development and implementation. At July 2018, the Health Board's annual appraisal compliance rate was better than the Wales average (76% and 67% respectively). Whilst not meeting the 85% national target, the Health Board's compliance rate has improved since last July (71%). The only staff group to meet the target is medical and dental. Appraisals form part of the annual revalidation process for

medical and dental staff and three-yearly revalidation requirements for registered nurses and midwifes. There has been a substantial improvement in statutory and mandatory training rates. In July 2018, the rate was 74% compared to 59% in July 2017. Allied Health Professionals are the only staff group meeting the 85% target. All statutory and mandatory training is accessed through the electronic staff record (ESR) which will also log when the training has been completed: compliance with the level one core skills training framework was 75% (November 2018) which the Health Board acknowledges requires improvement. The Health Board is currently reviewing its training provision as an initial demand and capacity analysis has indicated that that the Health Board is not delivering enough training to facilitate all staff maintaining their compliance with training requirements.

89 The Health Board has identified that current job planning compliance is lower than expected. To rectify the situation the Health Board has set a target of 90% compliance by December 2018 and for all job plans to be completed by the financial year-end. To monitor compliance rates, monthly reports are now submitted to Clinical Business Meetings (CBMs). The Finance, Performance and Workforce Committee also receives updates on job plan compliance through the workforce dashboard, but the Health Board recognises that presentation of this metric needs to be strengthened. Specifically, the dashboard was lacking trend data and Health-Board-wide compliance rates: these issues are being addressed.

90 The Finance, Performance and Workforce Committee receives a workforce dashboard each month, except for when the meeting is reserved for deep-dives and specific performance updates. The dashboard provides updates against the following six workforce areas: resourcing and recruitment, employee engagement, sickness absence, ESR and E-Systems roll out, personal development review and core mandatory training compliance and workforce utilisation. Workforce utilisation is demonstrated by showing figures for the supply of temporary registered nurses and healthcare support workers, medical agency expenditure and job planning compliance. The Board also receives the workforce dashboard at each meeting. The production and use of this dashboard are positive, however, the Health Board recognised that the dashboard was not adequately highlighting areas for the Board and committee to focus on. Since November 2018, the Health Board has made some improvements to performance reporting. For workforce, this has meant adding a coversheet to the workforce dashboard outlining the key points, highlights and lowlights related to workforce.

91 Our board member survey found that ten out of 15 members (67%) responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to workforce productivity compared with 40% of board members across Wales;

92 At the time of our audit work, the 2018 NHS Wales staff survey had just closed, and the results were not yet available. The Health Board learned that the response rate was only a 22% response compared with the Wales average (29%). The Health Board's response rate in 2016 was 38%. The Health Board is continuing to address the findings from the 2016 NHS Wales staff survey. The Health Board is also piloting pulse surveys across service areas with the aim of conducting all-staff surveys every six months. However, before rolling out this survey, the Health Board needs to understand the reasons for the low response rate to the national staff survey and take steps to try and secure better response rates in future staff surveys.

Managing the finances

93 We considered financial and budget management, financial controls, and operational support and processes. We found that the Health Board has a track record of achieving its statutory financial duties and has generally robust financial stewardship and management controls in place. However, there is a need to reduce the reliance on agency staff.

Achievement of financial objectives

94 Health Boards are subject to two statutory financial duties each year, under the NHS Finance Act (Wales) 2014. Firstly, they must spend within the Revenue Resource Limits (RRL) and the Capital Resource Limits (CRL) set by the Welsh Government, measured on a rolling three-year basis. Secondly, they must have their IMTP approved each year by the Cabinet Secretary for Health and Social Services.

95 The 2017-18 financial statements show that the Health Board underspent against its cumulative three-year RRL by £63,000 and against its cumulative CRL by £21,000, therefore meeting its statutory duty. Indications are that this duty will continue to be met in 2018-19. In its Monthly Monitoring Return issued to the Welsh Government for September 2018, the Health Board has year-to-date underspends of £77,000 against its RRL and £535,000 against its CRL and is forecasting to break even against both limits at the year-end.

96 The Health Board was able to return £3.0 million of brokerage to the Welsh Government in 2017-18 – effectively deferring this amount from their RRL from 2017-18 to 2018-19. The Health Board was able to achieve this position and still break even in the year by receiving additional funding from the Welsh Government (£1.8 million more than originally planned in its IMTP) and by over-achieving against its savings targets by £2.4 million. These amounts were offset slightly by additional cost pressures in areas, such as medical and nursing pay, drugs and other non-pay expenditure.

97 The Health Board has a good track record in respect of approval its three-year IMTP. The 2017-2020 IMTP was approved by the Cabinet Secretary for Health and Social Services in June 2017, while the 2018-2021 IMTP was approved in June 2018.

98 The Health Board's procurement arrangements are largely devolved to the NHS Wales Shared Services Partnership (NWSSP). There is an all-Wales Procurement Strategy, which the Health Board has signed up to. The NWSSP Procurement team have a local engagement strategy in place which was recently refreshed but needs to be agreed formally with the Health Board.

99 Management of procurement is through a service level partnership between the Shared Services Partnership and the Health Board, but we understand this is not proactively used to manage the 'contractual' relationship between the Health Board and the procurement provider.

100 As part of the Health Board's IMTP arrangements, there is a non-pay cross-cutting theme in place. The theme is led by the Director of Finance and the Head of Procurement, and performance is managed through the EPV Board, as well as the Non-Pay Strategy group. The non-pay cross-cutting theme achieves its targets. But, the executive-led Non-Pay Strategy group has not met since April 2018. We understand that the Health Board has good day-to-day relationships with the procurement service, and staff were complimentary on the support and guidance from the team. Additional procurement support is also being given to specific directorates, however, due to capacity limitations the procurement team are unable to offer this level of support across the Health Board. The Health Board could also adopt a more strategic approach in its procurement, to use it as a mechanism to help

deliver wellbeing of future generation objectives. This may, however, require a greater skill mix and resource in the procurement team and or an enhanced contribution and role by the Health Board's finance department.

Financial stewardship

101 The Health Board has a clear framework of roles and responsibilities, with appropriate control activities and processes in place. The Internal Audit service undertakes reviews of the 'financial governance and management' domain every year. In 2017-18, Internal Audit issued five reports in this domain, with only one of those reports on private and overseas patients leading to a 'limited assurance' opinion, which is a low proportion of activity within the Health Board. Its review of core financial systems gave an opinion of 'substantial assurance'.

102 Our own audit reporting during 2017-18 has not raised any material concerns over the Health Board's financial controls. The Audit Committee receives and reviews the outputs of Internal and External Audit on a regular basis, as well as the Health Board's Annual Governance Statement, which itself did not identify any significant concerns or failures of control.

103 The Health Board has a track record of meeting its statutory reporting requirements. Its draft and final financial statements were submitted to the Welsh Government in line with agreed deadlines. Similarly, the draft and final annual reports were produced in line with guidance from HM Treasury and in accordance with deadlines.

104 Regular finance reports are presented to the Finance, Performance and Workforce committee and the full Board. The structure and content of these reports are generally strong, with key findings and supporting detail clearly presented. The Director or Deputy Director of Finance also regularly attend Board or relevant Committee meetings. Management have engaged with IMs during the year to continuously improve the content and structure of these finance reports, to make them as clear and understandable as possible.

105 Our Board member survey found that 15 out of 15 (100%) members responding agreed that the information they receive gives them a good understanding about how the organisation performs financially compared with 97% of board members across Wales.

106 A Local Counter Fraud Service (LCFS) is in place to tackle fraud within the Health Board. Work in this area can be proactive (ie delivery of training, or review of internal policies/guidance) or reactive (review or investigation of specific allegations of fraud). The Health Board commissions this service from Cardiff and Vale University Health Board, with 1.5 full-time equivalent staff employed in its LCFS since the 2014-15 financial year.

107 However, the Health Board's counter-fraud landscape has developed in recent years. Its LCFS caseload has steadily increased, from 5 live investigations in 2014-15 to 20 in 2017-18. NHS Protect have provided a 'red' rating in the 'prevent and deter' domain in a recent review of the Health Board, due to internal policies not being reviewed by the LCFS. Furthermore, the impending boundary change (see paragraph 8) will increase the size of the Health Board significantly from April 2019. In response to the above challenges, the Health Board has reviewed its LCFS provision and counter-fraud service capacity will be increased from the 2019-20 financial year.

Financial management

108 The Health Board has a robust approach to financial management. Each directorate is allocated a Finance Business Partner (FBP), who meets at least monthly with directorate management to review progress against budget and identified savings plans. The Deputy Director of Finance oversees this process and meets with all FBPs each month to discuss issues arising at directorates.

109 This robust approach delivers consistent results for the Health Board. As noted above, the Health Board regularly meets its financial duty to break even over a three-year rolling period. In addition, performance against savings targets is strong, with 96% of savings achieved in 2016-17 and over 118% achieved in 2017-18. Furthermore, 60% of savings were classed as recurrent in both years.

110 The Health Board employs a Planning and Reporting team which acts as a 'business intelligence' function, providing costing and financial data to enhance decision-making by the Health Board. Detailed financial data is included in project appraisals for service change, allowing financial considerations to be fully considered by the Board alongside other factors when making decisions relating to service delivery.

111 The challenges in respect of relatively high use of agency staff highlighted earlier in this report will continue to present the Health Board with financial challenges.

Improving performance, efficiency and productivity

112 We looked at what the organisation is doing to improve performance, efficiency and productivity. We found that **the Health Board focuses on delivery of its key access targets and has examples of innovative ways of working to improve efficiency and productivity**.

Key waiting time targets

113 The Health Board is operating in a challenging environment, and while some performance metrics have improved the challenge is now to maintain this.

114 With regard to scheduled care, in March 2018, the Health Board delivered on its trajectory for referral to treatment times. This improvement has been supported by additional funding from the Welsh Government. Through its IMTP there has been a focus on the booking processes as well as a pathway transformation to deliver activities to improve pathway management for elective care. Work is also in progress to improve theatre utilisation and streamline processes for pre-assessment.

115 However, it is important that the Health Board maintains delivery of the referral to treatment time target throughout the coming year as this is technically a month-on-month target rather than an annual one. At the end of June 2018, 195 (1%) patients were waiting longer than 36 weeks to be seen compared to the Wales average of 3%.

116 In relation to unscheduled care, the Health Board is not achieving its four-hour emergency department target although performance is better than many other areas in Wales. Performance as at June 2018 was 90% compared with a Welsh average of 83%, and a national target of 95%. In the 2018-19 IMTP there are three specific objectives which involve looking at alternative interventions to provide alternative unscheduled care services for the elderly.

117 Follow-up outpatients remain a concern for the Health Board. The number of patients waiting for an outpatient follow-up (not booked) who are currently delayed past their agreed target date is 19,455,

and has been growing over the past four months. Work on clinical validation of follow-up lists is ongoing, and there has been a clear focus on outpatient follow-up appointments by the Quality Safety and Risk Committee.

118 Over the last 12 months there has been mixed performance in urgent suspected cancer performance but some improvement in relation to stroke performance measures, although the percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within four hours is low compared with other Health Boards in Wales.

Improving productivity and efficiency

119 Our work this year has considered the Health Board's arrangements for improving efficiency and productivity. We found that there is a good focus on prudent healthcare which is reflected in the IMTP and there have been some successes in this area, but further resources will be needed to fully embed the principles within directorates.

120 Compared to other health bodies in Wales, Cwm Taf Board members were more positive about the information they received in relation to service efficiency and care outcomes, although the responses to our board member survey indicates that scope exists to strengthen arrangements in both of these areas:

- nine out of 15 members (60%) responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to service efficiency compared with 52% of board members across Wales;
- seven out of 15 (50%) members responding agreed that the information they receive gives them a good understanding about how the organisation performs in relation to care outcomes compared with 47% of board members across Wales.

121 There is a clear focus on prudent healthcare and references to its importance throughout the IMTP. One of the Health Board's cross-cutting themes is 'Prevention and Improving Value from Healthcare', which is intended to embed prudent healthcare values. The executive lead for this theme is the Director of Public Health while the EPV Board monitors performance against the theme plan. The workplan for the group includes completion of opportunity analysis for interventions not normally undertaken, population heath management, science-based procurement and health outcomes measurement (ICHOM)[2]. The work of the prudent healthcare team is positive and shows a commitment from the Health Board in this area. Embedding prudent healthcare principles such that they are reflected in directorate IMTPs requires training and support; however, capacity within the prudent heathcare team is limited and prevents this.

122 Prudent healthcare principles are helping to reshape and modernise services. One example is Valley Steps, which is a new integrated service aimed at reducing demand and over-reliance on anti-depressant medication. At the same time, it reduces costs by reducing anti-depressant prescribing and supporting alternative interventions from traditional health services, eg mindfulness courses.

123 The Stay Well at Home (SW@H) service demonstrates where improvements to a service have not only helped in terms of prudent healthcare but also achieved financial savings and improved service user feedback. The SW@H service is a venture between the Health Board and local authorities to

[2] https://www.ichom.org/

improve engagement between health and social care within the A&E departments of the two main hospitals. The service aims to prevent health crisis, prevent avoidable hospital admission and prevent a lengthy hospital stay. A six-month evaluation of the project found that it had saved enough bed days to pay for its establishment and the NHS Wales Delivery Unit also found that delayed discharges because of problems between health and social care had reduced.

124 The Health Board has also taken steps to improve efficiency of outpatient services, for instance, by introducing text and remind services to reduce patient do not attends, which has had a positive effect.

Using informatics to support service delivery

125 We assessed the Health Board's arrangements to utilise technology to support service delivery. We found that the Health Board has an agreed digital health strategy, but challenges remain in securing the necessary resources to deliver it.

126 The Health Board has an agreed five-year digital strategic outline programme. This was first produced and agreed by the executive board in June 2017, and subsequently submitted to the Welsh Government. To implement the strategy, the Health Board requires capital funding totalling £17 million and £10.7 million revenue funding over the five-year period 2017-18 to 2021-22. Our 2017 Structured Assessment noted that the Health Board needed to break the strategy down into key deliverables and allocate financial resources accordingly. This work has been completed and each item on the digital health strategy is costed. The digital health strategy group prioritises capital funding based on the strategic needs of the Health Board.

127 The Internal Audit service reviewed the Digital Health Strategy and highlighted concerns that there is no ring-fenced funding for ICT. The lack of funding for implementing the informatics strategic outline programme may undermine the Health Board's ability to deliver strategic objectives. Capital monies allocated to ICT have been historically low and our previous work on ICT arrangements highlighted that ICT investment was less than other health boards.[3] In 2017-18 the initial allocation was £360,000 for rolling replacement only, despite a requirement for £1 million.

128 The Health Board has tried to progress some areas within the informatics strategic outline programme. For example, the Health Board applied for Welsh Government funding to support the digitisation of paper records project. Without the funding, the number of paper medical records will continue to increase exceeding the capacity of the Health Board's Williamstown medical records storage centre. The Health Board's bids have been unsuccessful to date.

129 In previous Structured Assessment reports, we commented on the movement of the ICT portfolio amongst executive directors. More recently, the Chief Operating Officer has taken on executive responsibility for ICT, which has created some welcome stability. Positively, the Health Board has been successful in recruiting a substantive Head of Information and Communications Technology (ICT) after previous interim arrangements.

[3] Wales Audit Office, Diagnostic Review of ICT Capacity and Resources, 2016.

Managing the estate and other physical assets

130 Finally, we considered how the estate and physical assets are managed. We found that the Health Board manages its assets well.

131 The Health Board has an overarching estates strategy and an asset management strategy in place. Work is ongoing to revise the estates strategy as it is due for renewal and needs to reflect the boundary changes coming into effect in April 2019. The Health Board also has a Capital and Estates Integrated Medium Term Business Plan, which outlines the service and key priorities for 2017-2020. Performance against this plan is monitored through the Clinical Business Meeting[4] arrangements.

132 The Health Board applies a risk management approach to help 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 unexpected equipment failure.

133 From a financial point of view the Health Board maintains a fixed asset register, which holds details of all assets owned by the Health Board including purchase date, value, revaluations, impairment, asset life and location. From an operational and maintenance point of view, the Estates department maintains an asset management system called TABS, which holds information regarding all buildings and the maintenance needs. This system also contains information on planned maintenance and replacement schedules. The information recorded is at a very detailed level, breaking down each building into its component parts (eg light switches, smoke detectors, plant rooms, piping, electrical sockets etc.). The Health Board is looking to replace this system as it is outdated and requires significant resource. The Estates directorate are exploring replacement now but want to wait until the transfer of services from Abertawe Bro Morgannwg University Health Board is complete to ensure the systems are compatible. The Health Board is also considering a four-facet survey[5] of the estate to gain a better understanding of the estate condition. Our review of the risk register within the Estates directorate has highlighted some issues with risks being out of date, and a need for a thorough review and update of the register.

[4] Clinical Business Meetings – where a small core of executive directors meet monthly with clinical and managerial leads of each directorate to provide oversight and performance management of the entire operation.

[5] A facet survey is an external condition review of the NHS estate and the number of facets relates to the scope of the survey.

Recommendations

Exhibit 2: 2018 recommendations

2018 recommendations
Implementing previous recommendations R1 We recommend that within 12 months, the Health Board fully implements the outstanding recommendations from our previous Structured Assessment (as detailed in Appendix 1).
Scheme of Delegations R2 The Health Board should update the Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.
Improve risk practice and assurance R3 To improve risk practice and provide assurance to the Board and Committees that risks to achieving strategic objectives are effectively managed, the Health Board should: a) undertake an organisational-wide review of the directorate risk registers to ensure they are up to date and reflect the current risks facing services, and; b) ensure timely ongoing review of all directorate risk registers.
Quality Governance R4 To improve quality governance arrangements the Health Board should: a) ensure the Quality Steering Group meets with the appropriate frequency; b) ensure that the quality report is more explicit at highlighting quality concerns and also articulates how the Health Board is learning lessons; c) consult with the public and service users when developing the new Quality Strategy; d) improve the quality and consistency of Quality, Safety and Risk Committee papers to ensure clarity and brevity, to enable areas of concern to be identified easily, to highlight action taken to address areas of concern and to demonstrate learning; e) audit the quality, safety and risk processes within directorates to gain assurance they operate effectively; f) review the relevance of organisation policies that the Quality, Safety and Risk Committee is asked to approve and reallocate responsibility to other committees; and g) provide bespoke induction for Independent Members newly appointed to the Quality, Safety and Risk Committee to ensure effective scrutiny and understanding of quality issues.

2018 recommendations
Audit tracker R5 The Audit Committee should ensure the tracker log records good information to enable Independent Members to review and take assurance that the recommendations are complete when removed from the tracker. R6 The Audit Committee tracker should be expanded to include the recommendations of other external agencies, eg Healthcare Inspectorate Wales and the Delivery Unit.
Information Communications and technology R7 The Health Board should take steps to strengthen the oversight arrangements in relation to ICT and Information Governance by: a) ensuring that minutes from the Digital Health Strategy Steering group and Information Governance group are scrutinised at the Quality, Safety and Risk Committee; and b) clarifying and articulating links between information governance and ICT to strengthen the oversight and scrutiny of the Trust's digital business. R8 The Health Board should develop a cyber security action plan to implement recommendations from the NHS Wales External Security Assessment and any other cyber security reviews as appropriate. It should also be used to ensure that cyber security arrangements are in place to meet the Health Board's needs.
National Fraud Initiative R9 We recommend that the Health Board put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed. We expect the Health Board to. a) commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; b) in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and c) ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.

Appendix 1

Progress implementing previous recommendations

Exhibit 3: actions in response to 2017 and outstanding previous recommendations

Recommendation	Action taken in response	Completed
R1 The Health Board's Quality Impact Assessment Tool, which must be completed for schemes over £100,000 currently asks directorates to consider the impact of their savings schemes on patient safety, clinical effectiveness, patient experience and staff experience. The Health Board should extend the template to also cover the impact of large savings schemes on other directorates and services, other health bodies and external partners and organisations.	Interdependencies, both internal and external, are now requested within the Key Service Change Tracker alongside the Quality Impact Assessment Score.	Yes.
R2 We found that the Health Board's IMTP peer review process does not fully identify potential cross-directorate working opportunities and supplication. The Health Board should review and strengthen the process to better facilitate joint savings schemes and identify similar or duplicate schemes.	For 2019 to 2022, each Directorate is required to list their priorities, including any service change. These priorities will be reviewed initially by planning business partners for cross directorate working opportunities and duplication and will then by a wider Assistant Director group. This intelligence will be shared with Directorates prior to them finalising their plans.	Partly- in progress recommendation.

Recommendation		Action taken in response	Completed
R3	We found that there can be complexities to cross-directorate working, especially if directorates do not directly benefit from savings schemes. The Health Board should develop a set of principles for directorates which encourages Health-Board-wide working.	Further work has been undertaken for 2019 to 2022 to better define how cross-cutting-theme savings opportunities impact on Directorates and where the benefits are realised.	Partly – in progress recommendation.
R4	We found the Health Board has limited project management and data analytics capacity and skills to support savings planning and delivery, especially for Health-Board-wide schemes. The Health Board should review and consider enhancing current project management and data analytics capacity and skills.	The UHB is currently reviewing the scope and capacity of the Programme Management Office with a view to growing its sustainable project management capacity. This will enable projects prioritised though the IMTP planning process to be more appropriately supported through project implementation and benefits realisation.	Partly – in progress recommendation.
R5	The Health Board should further refine the IMTP reporting process to include detailed information on milestones to enable Independent Members to understand the current performance in line with expected trajectory.	The UHB has, for 18/19, reviewed how best to monitor progress against the organisations objectives as set out in the IMTP. A revised process and quarterly report was instigated for quarter 1 and 2 2018/19. This revision has been positively received by the Board.	Partly – in progress recommendation.

Recommendation		Action taken in response	Completed
R6	The Health Board should ensure there is a detailed resourced action plan to enable delivery of the Digital Health Strategy.	The Digital Health Strategy is built on a set of annual priorities expressed over a five-year strategic staircase. Over the course of this year the strategy has prioritised the development of three business cases, with two that link into national procurements: digitisation of records is a foundational commitment to digitise 1.25m medical records, the final business case has been signed off and will shortly be shared with the Welsh Government to finalise funding routes; Emergency Department system procurement is due at Board in December 2018; and the Eprescribing and underpinning pharmacy system will come to Board before the end of the financial year 2018/19.	Partly

Recommendation	Action taken in response	Completed
R7 The Health Board needs to refine the quality of its papers presented to the Quality Safety and Risk Committee; • Making the papers more succinct and focussed; and • Consider the agenda management for example, bringing more complex issues to the beginning of the committee, and moving approval of policies to the latter end of the agenda	Work is continuing with this key Committee for Cwm Taf. During the year we the Chair has been appointed as the Vice Chair of the Board and has brought a different focus to the meeting and 2 new Independent Members joined in February 2018. Following discussion between the Chair and Vice Chair during the summer two additional Independent Members have been allocated to the Committee to assist with scrutiny bringing the total number to 5 from December 2018. Work is continuing to manage the agenda and the quality of the reports which although remains work in progress has assisted the Committee during the course of the year. The work planned from December 2018 onwards on the Clinical Governance Framework and the supporting structure to the Committee should also assist. This work also includes agreeing where policies are scrutinised and discussed before formal approval is requested at the QSR or any other Board Committee.	Partly

Appendix 2

Health Board's response to this year's recommendations

When the relevant committee has considered this report, we will insert a shortened version of the Health Board's response in the report before we publish it on the Wales Audit Office website.

Exhibit 4: management response to 2018 recommendations

Recommendation	Management response	Completion date	Responsible officer
R1 We recommend that within 12 months, the Health Board fully implements the outstanding recommendations from our previous Structured Assessment (as detailed in Appendix 1).			
R2 The Health Board should update the Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.			
R3 To improve risk practice and provide assurance to the Board and Committees that risks to achieving strategic objectives are effectively managed, the Health Board should: – a) undertake an organisational wide review of the directorate risk registers to ensure they are up to date and reflect the current risks facing services; and – b) ensure timely ongoing review of all directorate risk registers.			

Recommendation	Management response	Completion date	Responsible officer
R4 To improve quality governance arrangements the Health Board should: – a) ensure the Quality Steering Group meets with the appropriate frequency; – b) ensure that the quality report is more explicit at highlighting quality concerns and also articulates how the Health Board is learning lessons; – c) consult with the public and service users when developing the new Quality Strategy; – d) improve the quality and consistency of Quality, Safety and Risk Committee papers to ensure clarity and brevity, to enable areas of concern to be identified easily, to highlight action taken to address areas of concern and to demonstrate learning; – e) audit the quality, safety and risk processes within directorates to gain assurance they operate effectively; – f) review the relevance of organisation policies that the Quality, Safety and Risk Committee is asked to approve and reallocate responsibility to other committees; and – g) provide bespoke induction for Independent Members newly appointed to the Quality, Safety and Risk Committee to ensure effective scrutiny and understanding of quality issues.			

Recommendation	Management response	Completion date	Responsible officer
R5 The Audit Committee should ensure the tracker log records good information to enable Independent Members to review and take assurance that the recommendations are complete when removed from the tracker; R6 The Audit Committee tracker should be expanded to include the recommendations of other external agencies, eg Healthcare Inspectorate Wales and the Delivery Unit.			

Recommendation	Management response	Completion date	Responsible officer
R7 The Health Board should take steps to strengthen the oversight arrangements in relation to ICT and Information Governance by: – a) ensuring that minutes from the Digital Health Strategy Steering group and Information Governance group are scrutinised at the Quality, Safety and Risk Committee; and – b) clarifying and articulating links between information governance and ICT to strengthen the oversight and scrutiny of the Trust's digital business. R8 The Health Board should develop a cyber security action plan to implement recommendations from the NHS Wales External Security Assessment and any other cyber security reviews as appropriate. It should also be used to ensure that cyber security arrangements are in place to meet the Health Board's needs.			

Recommendation	Management response	Completion date	Responsible officer
R9 We recommend that the Health Board put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed. We expect the Health Board to. – a) commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; – b) in addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and – c) ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.			

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Health Board's response to this year's recommendations

When the relevant committee has considered this report, we will insert a shortened version of the Health Board's response in the report before we publish it on the Wales Audit Office website.

Exhibit 4: management response to 2018 recommendations

Recommendation	Management response	Completion date	Responsible officer
R1 We recommend that within 12 months, the Health Board fully implements the outstanding recommendations from our previous Structured Assessment (as detailed in Appendix 1).	We fully accept this recommendation and will complete the outstanding work within 12 months	March 2020	Chief Executive Officer
R2 The Health Board should update the Scheme of Delegation to reflect the requirements of the Nurse Staffing Levels (Wales) Act to designate a senior registered nurse to calculate nurse staffing levels.	The Scheme of Delegation will be amended to reflect the requirements of the Nurse Staffing (Wales) Act	1 April 2019	Director of Nursing Midwifery and Patient Experience / Interim Board Secretary
R3 To improve risk practice and provide assurance to the Board and Committees that risks to achieving strategic objectives are effectively managed, the Health Board should: – a) undertake an organisational wide review of the directorate risk registers to ensure they are up to date and reflect the current risks facing services; and – b) ensure timely on-going review of all directorate risk registers.	Fully accept the recommendation. Board Development session on risk management to be held before the Summer. The Head of Operational Health Safety and Fire will review all risk registers on Datix and work with Directorate Managers and Assistant Directors to review all risk registers and agree the process for ongoing review at Clinical /Corporate Business Meetings	To be held before the July meeting of the Audit Committee. To report to the October meeting of the Audit Committee	Director of Corporate Services and Governance / Board Secretary and all Directors with allocated risks

Recommendation	Management response	Completion date	Responsible officer
R4 To improve quality governance arrangements the Health Board should: – a) ensure the Quality Steering Group meets with the appropriate frequency; – b) ensure that the quality report is more explicit at highlighting quality concerns and also articulates how the Health Board is learning lessons; – c) consult with the public and service users when developing the new Quality Strategy – d) improve the quality and consistency of Quality, Safety and Rick Committee papers to ensure clarity and brevity, to enable areas of concern to be identified easily, to highlight action taken to address areas of concern and to demonstrate learning; – e) audit the quality, safety and risk processes within directorates to gain assurance they operate effectively; – f) review the relevance of organisation policies that the Quality, Safety and Risk Committee is asked to approve and reallocate responsibility to other committees; and	Fully agree with the recommendation to improve quality governance a) Quality and Safety Framework developed and agreed; new sub groups to be developed. b) Quality Report to be changed and more information provided through a dashboard approach; ensure lessons are learned are disseminated across the Health Board c) Will consult with service users and the public to develop the strategy d) Improving the information for the QSR will involve the sub groups meeting to discuss the operational detail and the Chair will report back to the Committee on a range of issues which will include learning lessons e) Directorates will be required to hold Governance meetings and a template to report exceptions to a sub group of the QSR for discussion will be developed f) New sub groups will be developed to over see and endorse policies; a report outlining the process including engagement and consultation will be clarified; the Committee will then provide final sign off. - Corporate - Clinical - Workforce	a) March 2019 (Completed) b) July 2019 c) December 2019 d) October 2019 e) October 2019 f) Corporate by June 2019 Clinical by June 2019 Workforce (Completed)	Director of Nursing Midwifery and Patient Experience Director of Nursing Midwifery and Patient Experience Director of Nursing Midwifery and Patient Experience Director of Nursing Midwifery and Patient Experience All Directors Director of Nursing Midwifery and Patient Experience Interim Board Secretary

Recommendation	Management response	Completion date	Responsible officer
– g) provide bespoke induction for Independent Members newly appointed to the Quality, Safety and Risk Committee to ensure effective scrutiny and understanding of quality issues.	g) All IMs will have a bespoke induction programme - wider discussion on scrutiny and quality issues will take place at a Board development session.	g) July 2019 (and ongoing as required)	Interim Board Secretary
R5 The Audit Committee should ensure the tracker log records good information to enable Independent Members to review and take assurance that the recommendations are complete when removed from the tracker; R6 The Audit committee tracker should be expanded to include the recommendations of other external agencies e.g. Healthcare Inspectorate Wales and the Delivery Unit.	R5 The reasons for removal of recommendations from the Audit Tracker will be clarified for IMs R6 A new tracker (based on the Audit Tracker) will be developed for recommendations of external agencies and regulators. The audit tracker is already of a considerable size and concerns were raised that adding recommendations could be lost. This new Tracker will report to the Quality Safety and Risk Committee.	R5 July 2019 R6 June 2019	Interim Board Secretary Director of Nursing Midwifery and Patient Experience / Interim Board Secretary / Operational Directors
R7 The Health Board should take steps to strengthen the oversight arrangements in relation to ICT and Information Governance by: – a) ensuring that minutes from the Digital Health Strategy Steering group and Information Governance group are scrutinised at the Quality, Safety and Risk Committee; and – b) clarifying and articulating links between information governance and ICT to strengthen the oversight and scrutiny of the Trust's digital business	R7 Following discussion, the Health Board has decided to have an ICT Committee which will subsume the work of the Information Governance Group. The Committee will report to Board on all matters. a) This recommendation will not be required as the ICT Committee will report to the Board b) The new Committee will scrutinise information governance / ICT and the work in relation to the digital strategy	R7 September 2019	ICT Lead Director / Interim Board Secretary

Recommendation	Management response	Completion date	Responsible officer
R8 The Health Board should develop a cyber security action plan to implement recommendations from the NHS Wales External Security Assessment and any other cyber security reviews as appropriate. It should also be used to ensure that cyber security arrangements are in place to meet the Health Board's needs.	R8 The ICT Committee will be responsible for overseeing the development of the cyber security action plan and implement the recommendations of the external security assessment.	R8 December 2019	ICT Lead Director
R9 We recommend that the Health Board put in place an action plan to ensure that the matches it receives in future NFI exercises are reviewed. We expect the Health Board to. – a) Commence review of the data-matches as soon as possible following the release of the next NFI matches in January 2019; – b) In addition to reviewing all the high priority matches recommended for review, carry out a review of a sample of the remaining data matches; and – c) Ensure that where data-matches have been reviewed, the NFI web application is updated to clearly record how matches were reviewed and the outcomes of those reviews.	R9 The HB will develop an action plan to ensure that the NFI exercises are reviewed. a) Work commenced on the data matches in April 2019 b) All high priority matches will be reviewed as well as a sample of the remaining data matches c) The NFI web application will be updated to record actions taken	October 2019	Director of Finance

Agenda item 6.1

AUDIT COMMITTEE FORWARD WORK PLAN 2019/20

Meeting Date – 1 APRIL 2019	**Lead**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP)	Director of Finance
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments Report	Director of Finance
• Local Counter Fraud Specialist update report **(CLOSED ITEM)**	'Acting' Director of Finance
• Post Payment Verification Reports to include comparable data from across Wales	Internal Audit & Assurance / Primary Care Lead
• Research & Development Policy for Approval	Director of Finance
• Financial Control Procedure – Medical Variable Pay	Director of Finance
• Standing Orders and SFI's	Board Secretary
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Annual Audit Plan 2019/20	Head of Internal Audit

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Draft Structured Assessment Report 2018 and Management Response (Executive Lead in attendance as appropriate)	Wales Audit Office lead
• Wales Audit Office Annual Audit Report 2018/19	Wales Audit Office lead
• Wales Audit Office – Annual Audit Plan 2019-20	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair
• Any other urgent Business	Chair
OTHER ITEMS	
• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• WHSSC Audit Recommendations Tracker Report	Committee Secretary
• WHSSC 'Draft' Annual Governance Statement 2018/19	Committee Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC 'Draft' Annual Governance Statement 2018/19	Board Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses ○ EASC Unscheduled Care Programme	Audit & Assurance / WAO

MEETING DATE – 13 MAY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• 'Draft' Annual Accounts & Financial Statements 2018/19	Director of Finance
• 'Draft' Accountability Report 2018/19	Board Secretary
• Finalised Medical Variable Pay Financial Control Procedure	Directors of Finance/Workforce & OD
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports outstanding from 2018/19 Internal Audit Plan (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

MEETING DATE – 30 MAY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Final Annual Accounts & Financial Statements 2018/19	Director of Finance

MEETING DATE – 15 JULY 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP)	Director of Finance
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments Report	Director of Finance
• Clinical Audit & Effectiveness Plan 2019/20 (and summary of progress against 2018/19 plan)	Medical Director
• Local Counter Fraud Specialist update report **(CLOSED ITEM)**	'Acting' Director of Finance
• Board Assurance Framework (BAF) – following discussion at Board Development/Integrated Governance Committee	Board Secretary
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Audit Reports (as per Annual Audit Plan 2018/19)	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair
• Any other urgent Business	Chair
OTHER ITEMS	

• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses	Audit & Assurance / WAO

MEETING DATE – 28 OCTOBER 2019	**LEAD**
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• Losses and Special Payments – Review of Plans and Priorities	Director of Finance
CHARITABLE FUNDS	
• Charitable Fund Balances for last quarter	Director of Finance
INTERNAL AUDIT & ASSURANCE	
• Head of Internal Audit Report	Head of Internal Audit
• Internal Audit Reports (any Limited or No assurance audit reports require the lead Executive Director to be present – and at the discretion of the Committee Chair for any Reasonable Assurance Rated Report)	Head of Internal Audit (Executive Leads as appropriate)

EXTERNAL AUDIT	
• WAO Progress report and any related external audit reviews	Wales Audit Office lead
• WAO Audit Reports (as per Annual Audit Plan 2018/19)	Wales Audit Office lead
ITEMS FOR INFORMATION	
• Only items for information raised in advance with the Chair will be discussed	Chair
• Any other urgent Business	Chair
OTHER ITEMS	
• Referrals to other Committees of the Board • Review of the Committee Forward Work Plan	Chair Chair
PART II MEETING – HOSTED BODIES	
• Apologies for Absence	Chair
• Welcome and Introductions	Chair
• Declarations of Interest	Chair
• Unconfirmed Minutes of the previous Audit Committee meeting for accuracy and matters arising	Chair
• Action Log	Board Secretary
INTERNAL CONTROL AND RISK MANAGEMENT	
• Audit Recommendations Tracker Report	Board Secretary
• WHSSC CRAF Update	Committee Secretary
• EASC Risk Register Update	Board Secretary
AUDIT & ASSURANCE	
• Receipt of Hosted Body Internal/External Audit Reports / Management Responses	Audit & Assurance / WAO

Meeting Date and Time	
Monday 1 April 2019	9.00am Rhondda & Cynon Rooms YMH
Monday 13 May 2019	9.00am Rhondda & Cynon Rooms YMH
Thursday 30 May 2019 – Annual Accounts Sign Off TO BE CONFIRMED	9.00am Rhondda & Cynon Rooms YMH
Monday 15 July 2019	9.00am Rhondda & Cynon Rooms YMH
Monday 28 October 2019	9.00am Rhondda & Cynon Rooms YMH