Bundle Audit Committee Part 1 28 October 2019

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4.3 Internal Audit Report - Data Quality 2018/19

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4.4 Internal Audit Report - Consultant Job Planning

4.4 Consultant Job Planning Final Internal Audit Report AC 28 October 2019.pdf

4.5 Internal Audit Report - Primary Care Cluster Plans

4.5 Primary Care Cluster Plans Final Internal Audit AC 28 October 2019.pdf

4.6 Internal Audit Report - Carbon Reduction Commitment

4.6 Carbon Reduction Commitment Internal Audit AC 28 October 2019.pdf

5 PART 5 EXTERNAL AUDIT

5.1 Wales Audit Office Update Report

5.1 Wales Audit Office Update Report AC 28 October 2019.pdf

5.2 Wales Audit Office Clinical Coding Update

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6 ITEMS FOR INFORMATION

6.1 Committee Forward Work Plan 2019/20

6.1 Forward work plan AC 28 October 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 Morgannwg University Health Board

AUDIT COMMITTEE
Monday 28 October 2019
Ynysmeurig House, Abercynon
9.30am

AGENDA

		Lead / Attachment
PART 1. PRELIMINARY MATTERS		
1.1	Apologies for Absence	Chair / Oral
1.2	Welcome and Introductions	Chair / Oral
1.3	Declaration of Interests	Chair / Oral
1.4	Unconfirmed Minutes of the meeting held on: • 15 July 2019 • 3 September 2019	Chair **Attachment**
1.5	Action Log	Chair **Attachment**
1.6	Matters arising, not considered within the Action Log	Chair / Oral
Part 2. INTERNAL CONTROL AND RISK MANAGEMENT		
2.1	Post Payment Verification 6 Monthly Update report	Director of Primary, Community & Mental Health **Attachment**
2.2	Counter Fraud Bribery and Corruption Policy and Response Plan	Head of Local Counter Fraud Services **Attachment**
2.3	Fighting Fraud Strategy	Head of Local Counter Fraud Services **Attachment**

2.4	Updated Audit Committee Terms of Reference	Interim Board Secretary/Director of Corporate Governance **Attachment**
2.5	Update on Model Standing Orders	Interim Board Secretary/Director of Corporate Governance **Attachment**
2.6	Audit Recommendations Tracker, to include: • Practice Note	Interim Board Secretary **Oral Update**
2.7	Procurements and Scheme of Delegation Report	Director of Finance **Attachment**
2.8	Losses & Special Payments Report	Director of Finance **Attachment**
2.9	SGS External ISO14001 Recertification Audit Report	Chief Operating Officer **Attachment**
2.10	Update on Standards of Behaviour Policy, to include: • Declarations of Interests; • Gifts & Hospitality	Interim Board Secretary/Director of Corporate Governance **Attachment**
2.11	Update on Committee Self-Assessment Process	Chair **Attachment**
Part 3. CHARITABLE FUNDS		
3.1	Charitable Fund Balances as at 31 August 2019	Director of Finance & Procurement **Attachment**
Part 4. INTERNAL AUDIT		
4.1	Internal Audit Progress Report	**Attachment**
4.2	Retention of Staff Follow Up – Limited Assurance	**Attachment**
4.3	Data Quality 2018/19 – Limited Assurance	**Attachment**
4.4	Consultant Job Planning – Limited Assurance	**Attachment**
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4.6	Carbon Reduction Commitment – Substantial Assurance	**Attachment**
Part 5. EXTERNAL AUDIT		
5.1	Wales Audit Office Update Report	Wales Audit Office **Attachment**
5.2	Wales Audit Office Clinical Coding Update	Wales Audit Office **Attachment**
Part 6. ITEMS FOR INFORMATION		
6.1	Committee Forward Work Plan 2019/2020	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 • 9.00am Monday 20 January 2020	
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 has been held in private session.		

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 15 JULY 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

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

IN ATTENDANCE

David Jones	-	Local Counter Fraud Specialist
Len Cozens	-	Head of Counter Fraud
David Thomas	-	Wales Audit Office
Paul Dalton	-	NWSSP – Internal Audit & Assurance
Emma Samways	-	NWSSP – Internal Audit & Assurance
Gwenan Roberts	-	Head of Corporate Services
Mark Thomas	-	Deputy Director of Finance
Melanie Harries	-	Welsh Government Delivery Unit
Jessica Miles	-	Graduate Trainee (Observing)
Eifion Jones	-	NWSSP – Internal Audit & Assurance
Kathrine Davies	-	Committee Secretariat

AC/19/093 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting, including Melanie Harries from the Delivery Unit and Jessica Miles, Graduate Trainee who was observing the meeting.

AC/19/094 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Gareth Lucey, Sara Utley, Steve Webster, Elisabeth Williams and Robert Williams.

AC/19/095 **DECLARATIONS OF INTERESTS**

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

AC/19/096 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 13 MAY 2019.**

The minutes of the meeting held on 13 May 2019, were **CONFIRMED** as a true and accurate record, subject to the following amendments:-

Unconfirmed

Page 14: AC/19/077 – Audit Recommendations Tracker – first paragraph line 2, insert 'made' at the end.

AC/19/096 **'UNCONFIRMED' MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 30 MAY 2019.**

The minutes of the meeting held on 30 May 2019, were **CONFIRMED** as a true and accurate record.

AC/19/097 **MATTERS ARISING**

There were no matters arising.

AC/19/098 **AUDIT COMMITTEE ACTION LOG**

The Committee Action Log from the meeting held on 13 May 2019 was reviewed by Members and the following was **NOTED:**

18/028 – Members **NOTED** that the Chair had met with the Auditors to discuss the Audit Tracker process. Members were advised that a practice note would be developed for staff in receipt of audit reports and the process that needs to be followed. Once finalised this would be shared. Members discussed the Tracker and **AGREED** that Counter Fraud involvement should be included.

19/023 – Internal Audit Report Raising Concerns – Members **NOTED** that this remained in progress and an update would be brought to the October 2019 meeting.

19/039 - Internal Audit Report Common Issues Identified within Directorate Reviews. Members **NOTED** that the Internal Audit Report had been circulated to Directorate Managers, Assistant Directors and Local Managers. Jayne Sadgrove queried whether the report had been received at the Executive Board. Gwenan Roberts confirmed that it had been sent to the two Executive Directors that managed Directorates. The Chair advised that it would be helpful if it was submitted to the Executive Board for information.

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/099 **AUDIT COMMITTEE ANNUAL REPORT 2018/19**

Gwenan Roberts presented the draft Annual Report for 2018/19 which included Committee Self-Assessment and revised Terms of Reference.

Following discussion, members **AGREED** to make the following minor changes to the report:

Unconfirmed

- Foreword should also include thanks to Counter Fraud.
- Page 8 – Paul Griffiths- Chair from January 2019 and not April.
- Page 12 – Water Safety Report – the draft rating had now changed and needed to be reflected in the finalised report.

With regard to the Committee Self-Assessment, Members **AGREED** that a separate session would be held outside of the meeting to progress this issue.

Members discussed the Terms of Reference and **AGREED** that the comments raised would be included in the Terms of Reference and would be approved via Chair's action.

Members **RESOLVED** to:

- **ENDORSE** the draft Audit Committee Annual Report for 2018-2019 for approval by the Health Board, subject to the suggested changes.
- **AGREE** Chair's Action to the Terms of Reference, subject to the suggested changes.
- **AGREE** that a separate meeting would be held to discuss the Committee's Self-assessment

AC/19/0100 **AUDIT RECOMMENDATIONS TRACKER**

Members **RECEIVED** the Audit Tracker which was presented by Gwenan Roberts.

Members **NOTED** that the Audit Tracker was in urgent need of a refresh. Members were of the opinion that there was too much narrative which in some cases did not relate specifically to the recommendation that had been made.

The Chair advised that he had met with Internal and External Audit on how to make the Tracker more effective. As discussed earlier, a practice note was in the process of being developed to aid staff in receipt of audit reports and would be shared with Members.

Members **AGREED** that the Audit Tracker would be reviewed in more detail outside of the meeting and discussed as part of the special meeting that would be arranged for the Committee Self-Assessment at the end of August/early September 2019.

The Chair advised that he would be writing to individual Senior Managers setting out what the Committee required in order to gain assurance.

Unconfirmed

Members **RESOLVED** to:

- **NOTE** the report
- **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.
- **REVIEW** the Audit Tracker at a special meeting.
- **AGREE** that the Chair would write to individual Senior Managers about these matters to coincide with the circulation of the agreed Practice Note.

AC/19/101 **PROCUREMENT AND SCHEME OF DELEGATION REPORT**

Members **RECEIVED** the Report which was presented by Mark Thomas.

Members **NOTED** the position on procurement matters for the period 1 March 2019 to 31 May 2019.

Members **NOTED** the update regarding Purchase to Pay and **AGREED** that the Scheme of Delegation be revised to include an additional category for Final Pay Controls.

Members **RESOLVED** to:

- **NOTE** the report
- **NOTE** the update regarding Purchase to Pay.
- **ENDORSE** the revision to the Scheme of Delegation.

AC/19/102 **LOSSES AND SPECIAL PAYMENTS REPORT**

Members **RECEIVED** the report which was presented by Mark Thomas.

Members **NOTED** the annual budget for net claim expenditure for 2019-20 and the under-spend on claims of £324k had been included within the Health Board's position as at the 31 May 2019. Members **NOTED** that the under-spend was expected to be phased-out as the impact of the claim expenditure for the Bridgend population started to materialise.

Members **RESOLVED** to:

- **NOTE** the losses and special payments made for the period 1 March 2019 to 31 May 2019.

Unconfirmed

AC/19/103 **FINANCIAL CONTROL PROCEDURE MEDICAL VARIABLE PAY**

Members **RECEIVED** the verbal report from Mark Thomas.

Following discussion, Members **AGREED** that the matter should be escalated to the Executive Team due to the concerns raised in relation to the high levels of Agency Locum Costs.

Members **AGREED** to receive a further update at the October 2019 meeting.

Members **RESOLVED** to:

- **NOTE** the verbal report
- **ESCALATE** to the Executive Team
- **RECEIVE** a further update at the October 2019 meeting.

AC/19/104 **CLINICAL AUDIT FORWARD PLAN 2019-2020**

Members **RECEIVED** the report which provided assurance to the Committee that a Clinical Audit Forward Plan 2019-20 for CTMUHB was in place along with the associated Clinical Audit Operational Plan.

Members **NOTED** that the Plan ensured that robust evidence of the monitoring and escalation of audit compliance was in place, and that audit outcomes were an integral part of the organisation's continuous improvement programme of work.

Members **NOTED** that no progress had been made as yet to the Clinical Audit Management system and **AGREED** that this item be referred to the Quality, Safety & Risk Committee.

Members **RESOLVED** to:

- **NOTE** the report
- **REFER** the matter of the Clinical Audit Management system to the Quality, Safety & Risk Committee.

PART 3. CHARITABLE FUNDS

AC/19/105 **CHARITABLE FUND BALANCES AS AT 31 MAY 2019**

Members **RECEIVED** the report which was presented by Mark Thomas.

Unconfirmed

Members **NOTED** the successful completion of the name change of the Charitable Funds with the Charity Commissioner. Members discussed whether a new Charitable Funds would now be required and **AGREED** that a meeting should be held with Independent Member Trustees and the Director of Finance to discuss prior to the next Trustees Meeting. Members **AGREED** that the Health Board Chair would need to be briefed.

Members **RESOLVED** to:

- **NOTE** the report
- **AGREE** that a meeting be held to discuss the requirement of a new Charitable Funds.

PART 4. INTERNAL AUDIT

AC/19/106 **INTERNAL AUDIT PROGRESS REPORT**

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

Health and Care Standards:	Reasonable Assurance
Surgery – Compliance:	Reasonable Assurance
Surgery – Management Arrangements:	Individual Assurance ratings (as contained in Table 1 of the report)
Water Safety:	Reasonable Assurance
Prince Charles Hospital Project:	Substantial Assurance
Radiology – Compliance:	Individual Assurance ratings (as contained in Table 1 of the report)
Freedom of Information:	Substantial Assurance

Paul Dalton advised that the Governance Arrangements, Quality, Safety & Risk Committee had been paused due to Healthcare Inspectorate Wales currently undertaking a review and would be picked back up later on in the year.

Members **NOTED** the report also identified progress being made against the plan for 2019/20 and it was **NOTED** that eight of the reports were being presented to the Committee today.

Members were advised that there was no update with regard to the Retention of Staff Follow-Up Review and this would be brought to the October 2019 meeting.

Unconfirmed

Members **NOTED** that with regard to Freedom of Information, the responses reviewed had been accurate, complete and dealt with within the defined timescales and where exemptions were used, were generally valid. Members congratulated the Information Government Team on the excellent work undertaken.

Members **RESOLVED** to:

- **NOTE** the report.

INTERNAL AUDIT & ASSURANCE AUDIT REPORTS

Water Safety – Reasonable Assurance

Eifion Jones presented the report and advised that the Water Safety audit was commissioned in order to evaluate the associated processes and procedures that support its management and control. The audit assessed compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01, Safe Water in Healthcare Premises.

Members **NOTED** the 10 actions contained within the report and were advised that a further update would be brought back to the October 2019 meeting.

Members were advised that there had been some problems with management responses in the Bridgend area.

Members **AGREED** that the report should be referred to Quality, Safety & Risk Committee for information.

Members **RESOLVED** to:

- **NOTE** the report
- **REFER** to Quality, Safety & Risk Committee for information
- **RECEIVE** a further update at the October 2019 meeting.

Health & Care Standards – Reasonable Assurance

Emma Samways presented the report which had been given a reasonable assurance rating.

Members **NOTED** that scoring of Self-Assessments appeared to be subjective and no guidance in relation to scoring which could lead to inconsistencies across wards or areas. Action plans were now in place and training sessions would be held.

Unconfirmed

Members **RESOLVED** to:

- **NOTE** the report.

Prince Charles Hospital redevelopment – Reasonable Assurance

Eifion Jones presented the report which had now received a substantial assurance rating.

Members **NOTED** that all of the 21 Actions had been fully implemented. Members **AGREED** that the Chair would write to the Director of Planning and Performance expressing how pleased the Committee were that all actions had been fully implemented.

Members **RESOLVED** to:

- **NOTE** the report.

Handover of Care at Emergency Departments – Follow Up
Paul Dalton presented the report.

Members were advised that the purpose of the review was to assess whether health boards had taken appropriate action in response to the findings raised following the Handover of Care at Emergency Departments review in 2017/18 where an opinion of 'limited assurance' was given. Whilst the review was included in the Welsh Ambulance Services Trust (WAST) Internal Audit Plan, all six health boards that had Emergency Departments were engaged in the fieldwork of the review and the draft report was issued to the six health boards for consideration.

Members **NOTED** that although there were 8 recommendations, there were none specific to Cwm Taf Morgannwg UHB.

Members **RESOLVED** to:

- **NOTE** the report

Directorate Review Surgery – Management Arrangements/Compliance

Emma Samways presented the two reports together.

Members **NOTED** that a number of actions required to be implemented in terms of Clinical Business Meetings.

Members were advised that the Directorate used the Datix Risk Management database to record, monitor and update its risks. However, the review of the risk register on Datix showed that

Unconfirmed

2017/18 risks had passed their review date. Whilst there could have been a review of the risks, there was no evidence of this recorded within Datix. Members **NOTED** that it had been identified that eight risks had a risk handler attributed to them who was no longer an employee of the Health Board.

Members **NOTED** that whilst work remained to be undertaken, good progress had been made to date.

Members **RESOLVED** to:

- **NOTE** the report

Directorate Review Radiology – Management Arrangements/Compliance

Paul Dalton presented the two reports together and had received a reasonable assurance rating.

Members were advised that the key findings were that the Terms of Reference for the main groups that oversee the governance arrangements within the Directorate were still in draft form. CBMs and Operational Group meetings were not held monthly in line with the Terms of Reference and core members of the groups were not adequately represented. Members were of the opinion that as discussed earlier under the Audit Tracker, it was important that Senior Managers were aware of how to manage and mitigate risks and how to deal with audit reports. Members **AGREED** that Workforce Business Partners should be made aware of such issues and should be regularly attending CBMs. This would be fed-back to Anne Phillimore.

Members **RESOLVED** to:

- **NOTE** the report

Freedom of Information Review – Substantial Assurance

Paul Dalton presented the report.

Members **NOTED** that the responses reviewed had been accurate, complete and dealt with within the defined timescales. Members congratulated the Information Governance Team on the excellent work that had been undertaken.

Members **RESOLVED** to:

- **NOTE** the report

Unconfirmed

PART 5. EXTERNAL AUDIT

AC/19/107 **WALES AUDIT OFFICE UPDATE REPORT**

Members **RECEIVED** the report which was presented by Dave Thomas.

Members **NOTED** that there had been a slight delay with Clinical Coding but that this had now been received.

Members **RESOLVED** to:

- **NOTE** the report

AC/19/108 **TERMS OF REFERENCE JOINT REVIEW OF QUALITY GOVERNANCE BY WALES AUDIT OFFICE AND HEALTHCARE INSPECTORATE WALES**

Members **RECEIVED** the Terms of Reference for the Joint Review of Quality Governance which was presented by Dave Thomas.

Members were advised that the Health Board had responded superbly to the request for documents**.**

Members **NOTED** that Independent Members had not been mentioned as an evidence source within the Methodology. Dave Thomas confirmed that he would amend to reflect this.

Members discussed the audit fee. Dave Thomas advised that there could be a small addition to the fees.

Members **RESOLVED** to:

- **NOTE** the Terms of Reference

PART 6. ITEMS FOR INFORMATION

AC/19/109 **COMMITTEE FORWARD WORK PLAN 2019/2020**

Members **RECEIVED** and **NOTED** the Forward Work Plan for 2019/2020.

PART 7. ITEMS FOR INFORMATION

AC/19/110 **ITEMS FOR REFERRAL TO OTHER COMMITTEES**

Members referred the following items:

Unconfirmed

- Internal – Commissioning to the Finance, Performance & Workforce Committee for information;
- Internal Audit Report – Annual Quality Statement to the Quality, Safety & Risk Committee for information.

AC/19/111 **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 09.00 hrs on Monday 28 October 2019.

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Paul Griffiths, Chair

Date .....

Unconfirmed

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE ADDITIONAL AUDIT COMMITTEE HELD ON 3 SEPTEMBER 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT

Paul Griffiths	-	Independent Member (Chair)
Jayne Sadgrove	-	Independent Member
Dilys Jouvenat	-	Independent Member

IN ATTENDANCE

David Thomas	-	Wales Audit Office
Paul Dalton	-	NWSSP – Internal Audit & Assurance
Emma Samways	-	NWSSP – Internal Audit & Assurance
Steve Webster	-	Director of Finance
Georgina Galletly	-	Interim Board Secretary/Director of Corporate Governance
Gwenan Roberts	-	Head of Corporate Services
Emma Walters	-	Committee Secretariat
David Jenkins	-	Independent Advisor to the Board
Kelechi Nnoaham	-	Director of Public Health (In part)
Clare Williams	-	Assistant Director of Planning & Partnerships (In part)
Julie Keegan	-	Assistant Director Commissioning (In Part)
John Palmer	-	Chief Operating Officer (In part)

AC/19/112 **WELCOME AND INTRODUCTIONS**

Paul Griffiths, Chair, **welcomed** everyone to the meeting and introductions were made. Paul Griffiths advised that Members had held a private meeting earlier to review and discuss the Committee Self-Assessment for the Audit Committee Annual Report 2018/19.

AC/19/113 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Maria Thomas, Gareth Lucey, Sara Utley, David Jones and Elisabeth Williams.

AC/19/114 **DECLARATIONS OF INTERESTS**

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

PART 2. INTERNAL CONTROL AND RISK MANAGEMENT

AC/19/115 **REVIEW OF THE AUDIT RECOMMENDATIONS TRACKER – HIGH RISK RECOMMENDATIONS**

Paul Griffiths advised Members of the reasons the meeting was being held which was as a result of a number of outstanding high risk recommendations being presented to the Committee at the last meeting, with some falling well behind their original implementation date. It had therefore been decided to invite key colleagues to the meeting to provide an update against progress.

Internal Audit Review - Wellbeing & Future Generations Act

Kelechi Nnoaham was in attendance to provide an update against two outstanding recommendations. The following key updates were received:

Recommendation 1

- This recommendation related to objective setting and reporting;
- Objectives had been set as part of the Integrated Medium Term Plan (IMTP) process in which there were risks associated in doing this. It had been felt that wellbeing risks could become lost;
- Consideration had been given as to whether reporting of actions had been correct;
- This piece of work was very resource dependent;
- The capacity to report would remain an ongoing challenge.

A discussion was held as to whether this action could be considered as completed as the Committee had struggled to determine whether the action had been completed from the narrative provided. Emma Samways advised that Internal Audit could see that this had been referenced within the IMTP and that evidence would be required where this was being reported into.

Members **NOTED** that there were different opinions in place as to the interpretation of the recommendation which was why the practice note had been issued which sets out very clear guidance. Kelechi Nnoaham advised that he had found this note helpful and that if he had applied the note to the original recommendation he would have provided a different response.

Recommendation 2

- The recommendation related to whether the establishment of a steering group had been considered as value for money in the context of other pressures;
- The response highlighted that there was recognition that slow progress had been made against this recommendation;
- It was highlighted that the recommendation related to the need to have clear plan in place and did not advise that a steering group needed to be in place. The recommendation also suggested that more resource was required to undertake the work.

Georgina Galletly advised that she found it difficult to find clarity of the exam questions without having sight of the original recommendations and advised that if the objectives had been reflected in the Annual Report and had been included in the IMTP then the action could be considered to be completed. Georgina Galletly suggested that Kelechi Nnoaham may require some support from management to enable closure of the recommendations.

Following discussion, it was suggested that Kelechi Nnoaham and Paul Dalton meet outside of the meeting to discuss the issues highlighted and whether the recommendations could be closed. An update would be presented to the October meeting.

Internal Audit Review - Service Change Plans – Early Cancer Diagnosis

Clare Williams was in attendance to provide an update against one outstanding recommendation. Clare Williams confirmed that she had been provided with a copy of the practice note which she had found to be helpful.

Members **NOTED** that the recommendation related to how SMART the objectives were in relation to the Service Change Plan, with the recommendation advising that objectives needed to be made smarter with more focus placed on measurement. Members **NOTED** that the resolution of this action had been slightly delayed as a result of the introduction of the Single Cancer Pathway. Clare Williams advised that governance processes had now improved with an expected sign off date of 13 September.

Following discussion, Members **AGREED** that this recommendation could be considered as completed.

Internal Audit Review - Commissioning

Julie Keegan was in attendance to provide an update against one outstanding recommendation. Members NOTED that the recommendation related to the development of a register of commissioning arrangements.

Members **NOTED** that the Audit had focussed on the interface between Powys and Cwm Taf Health Boards where it had been identified that there was a Service Level Agreement held within the Directorate that the Team were not aware of and there was concern that there would be other similar cases in the system. It was therefore agreed that a central log should be developed. Members **NOTED** that a repository of SLA's had now been developed and would be populated further for other Health Board areas over the next few months. It was hoped that the exercise would be completed by 2020.

Following discussion as to whether Members felt that this action could now be marked as completed, Members **AGREED** that the recommendation would need to be kept on the tracker with the deadline extended to the end of the financial year.

Internal Audit Review - Private & Overseas Patients

John Palmer was in attendance to provide an update against one outstanding recommendation. Members **NOTED** that good progress had been made against the recommendation and that an Overseas Manager had been in post since April and would be taking forward key pieces of work. Emma Samways confirmed that a follow up audit undertaken identified that this recommendation was now medium and not high.

Following discussion, it was **AGREED** that the detail on progress made would be shared with Internal Audit to determine whether this recommendation could now be closed.

Internal Audit Review - JAG Accreditation

John Palmer provided Members with an update. Members **NOTED** that further work was being undertaken to obtain accreditation at RGH and PCH.

Emma Samways confirmed that a follow up review had been undertaken which suggested that this recommendation could be closed. Members **AGREED** to close the recommendation in its entirety.

Paul Griffiths expressed his disappointment at not receiving an update on this matter in advance of the meeting.

Internal Audit Review - Facilities Management

John Palmer presented Members with an update against one outstanding recommendation. Members **NOTED** that the Team felt that the original recommendation had been discharged and that issues which had occurred since the recommendation had been made had made the position more complex.

Emma Samways advised that when the audit was undertaken there had been recognition that the recommendation would be complex and advised that a follow up review would be undertaken into this area as it had been given a limited assurance rating.

Following discussion, Members **AGREED** that this recommendation would remain on the tracker with a revised implementation date of 1 January 2020.

Internal Audit Review - Risk Management Follow Up

John Palmer provided Members with an update against the one outstanding recommendation and advised that the Lead Officer for Cancer was the Medical Director, with John Palmer being the Operational Lead. Members **NOTED** that work was being undertaken to simplify the programme arrangements for Cancer and the Health Board was about to commence reporting on the Single Cancer Pathway. John Palmer advised that a detailed discussion was held at the last Programme Board meeting regarding the risk register and believed that this addressed the recommendation.

Dilys Jouvenat advised that the original recommendation questioned whether any significant risks were now being escalated. Members **NOTED** that no risks had been escalated from the last Programme Board meeting and **NOTED** that this may need to be considered moving forward. A discussion was held as to whether a follow up review would be undertaken and Paul Dalton advised that this could be followed up in the overall review of Risk Management arrangements.

Internal Audit Review - Cyber Security

John Palmer presented an update against two outstanding recommendations. In relation to the first recommendation, Members **NOTED** that Cyber Security was reporting into the Digital Strategy Steering Group and that feedback received from the Structured Assessment Review undertaken by Wales Audit Office suggested a further level of governance for Information, Communication and Technology (ICT) and Information Governance. Members **NOTED** that Ian Wells had now joined the organisation as the Independent Member for ICT and Information Governance.

In relation to the second recommendation, Members **NOTED** that two Cyber Security posts were almost in place with another post pending funding release.

Paul Griffiths requested that a further review of the recommendations and responses was undertaken by John Palmer and that an update was provided to the Committee at its next meeting.

Wales Audit Office Review – Follow Up Outpatients Not Booked (FUNB)

John Palmer presented Members with an update against 3 outstanding recommendations, which had been outstanding for some time. Members **NOTED** that FUNB had been discussed by the Board and its Committees a number of times and advised that a programme of work had been put into place with addressed the questions raised in the original recommendations. Members **NOTED** that harm was being reported whenever it presented.

Paul Griffiths recognised the number of discussions held on this matter and asked whether a review of the recommendations could be undertaken to determine whether the recommendations had been addressed. Paul Griffiths also highlighted that the narrative was too detailed.

Dave Thomas advised that the Wales Audit Office were satisfied that there had been significant work undertaken and added that a follow up review identified that actions had not been closed as originally stated. Dave Thomas advised that it was felt that the reporting into the Quality, Safety & Risk Committee was sufficient and there was nothing further that could be undertaken.

Dave Thomas advised that further information would be helpful on how clinical risk was being assessed in relation to the numbers of patients not booked, the numbers of patients who had been booked and delayed on their target date and the specialties which were holding the greatest risk. Members **NOTED** that two recommendations required further update and that one recommendation could be closed.

Wales Audit Office Review - Discharge Planning

John Palmer provided Members with an update against one outstanding recommendation and apologised that this recommendation had not been completed. Members **NOTED** that a new post holder was now in post and would be taking this forward, with a revised completion date of November 2019.

Dilys Jouvenat highlighted that the original target date for completion was September 2018 and questioned what had prevented this recommendation from being completed. John Palmer advised that this had just been de-prioritised by the Team.

Paul Griffiths advised that the practice note highlighted that early warning of any lapse in meeting target dates would need to be escalated to the Committee. Members **NOTED** that the practice note would be issued widely amongst Teams.

Internal Audit Review – Fire Management

Gwenan Roberts provided Members with an update against one outstanding recommendation and advised that the Health Board were still awaiting the development of a national database, although there were a number of local systems in place to assist with the auditing of fire risk assessments.

In response to a question raised by Jayne Sadgrove as to whether existing systems helped to manage the risk, it was suggested that a review was undertaken as to what approaches were being undertaken by other Health Board's regarding the capturing of risk assessments. Members **AGREED** that this would remain on the audit tracker until more information had been obtained.

Internal Audit Review – Raising Concerns

Gwenan Roberts presented Members with an update against one outstanding recommendation and advised that nearly all staff working within the Health Board had been issued with a NADEX account which enabled them to access sharepoint.

Members **NOTED** that Raising Concerns had been highlighted as a key policy and the organisation had changed the way it communicated with staff. Members **NOTED** that the recommendation had been partially completed and would always remain an ongoing matter to address.

Members **NOTED** that Raising Concerns would be embedded into the Values & Behaviours work that was in the process of being discussed by the Board and was closely linked to the work being undertaken on Bullying, Harassment and Abuse.

Emma Samways advised that the review had been allocated a limited assurance rating and was in the process of being followed up, with the aim to present the report to the October meeting of the Committee.

Internal Audit Review – Risk Management New

Gwenan Roberts presented an update against one outstanding recommendation and reminded Members that a Board Development discussion had taken place on Risk Management and Risk Appetite. Members **NOTED** the further work would be required to review the approach to risk management which would result in the Board Assurance Framework being adapted. Members **NOTED** that this would not be an insignificant piece of work and would take between 12-18 months to complete.

Following discussion, Georgina Galletly **AGREED** to review the timescales identified and provide a further update at the October Audit Committee.

Wales Audit Office Review – Structured Assessment 2018

Gwenan Roberts provided Members with an update and advised that the recommendation stated that the report's recommendations would be finalised and received by the April 2019 Audit Committee, which had been completed. Members **NOTED** that a number of recommendations sat beneath this overarching recommendation.

A discussion was held as to who was tracking progress against each individual recommendation within the structured assessment, and it was suggested that for the next meeting this section should be expanded to include other recommendations, for example, targeted intervention. Members **NOTED** that this would be discussed further outside of the meeting.

A discussion was held in relation to Internal Audit Advisory reviews and it was **NOTED** that these reviews would not have an opinion set against them but would still include recommendations.

Jayne Sadgrove made reference to a recommendation made within the Structured Assessment regarding the introduction of a tracker system for other external agency reviews, for example, Healthcare Inspectorate Wales, which would then report into the Quality, Safety & Risk Committee. Jayne Sadgrove also questioned how it could be ensured that all recommendations were being captured between Committees. Members **AGREED** that a procedural description would be required as to what the process would be.

Georgina Galletly advised a commitment had been made to develop a register which identified all regulatory inspections, with a view to have an expected programme of inspections also. Members **NOTED** that it was envisaged that the register would be presented to Audit Committee for review and monitoring and there would be a need to be mindful as to the Audit Committee's role. Georgina Galletly **AGREED** to provide Paul Griffiths with an update on the monitoring process being proposed.

Paul Griffiths advised that the Audit Committee would need to have sight of the Quality & Governance Framework which the Committee had not yet been presented with.

Dave Thomas questioned what role the Integrated Governance Committee would take in this matter. Georgina Galletly advised that this Committee and its purpose was currently in the process of being reviewed by the Chair.

PART 4. OTHER MATTERS

AC/19/116 **ANY OTHER URGENT BUSINESS**

There was no other business to report.

AC/19/117 **CLOSE OF THE MEETING – DATE AND TIME OF NEXT MEETING:**

The next meeting of the Committee would be held at 09.00 hrs on Monday 28 October 2019.

.....

Paul Griffiths, Chair

Date .....

AUDIT COMMITTEE ACTION LOG
FOLLOWING MEETING ON 15 JULY 2019

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT October 2019
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	**On agenda**
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	**To be confirmed**
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	**Follow Up Review 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	**In progress** Work remains ongoing in relation to refining the audit tracker
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	**Completed**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT October 2019
19/059	1/4/19	Charitable Funds	A discussion was held as to whether the Committee had the authority to approve the actions proposed for registering the name change and revised objects with the Charity Commissioner. Following discussion, Gwenan Roberts **AGREED** to seek advice from the UHB Chair as to whether the Committee had this authority.	May 2019	Interim Board Secretary	**Completed**
18/028	15/07/ 2019	Audit Tracker Process	Practice Note to be developed for staff in receipt of Audit Reports outlining the process that needed to be followed. Practice note to be shared with Audit Committee Members once developed. Counter Fraud involvement to be included in the tracker	October 2019	Interim Board Secretary	**Completed** **Completed** **In progress**
19/099	15/07/ 2019	Audit Committee Annual Report 2019/2019	Annual Report to be amended with suggested amendments made by the Committee. Separate session to be held to discuss the Committee Self-Assessment. Terms of Reference to be approved by Chairs action following suggested amendments made by Committee Members	October 2019	Interim Board Secretary	**Completed** **Completed** **On agenda**

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT October 2019
19/100	15/07/ 2019	Audit Recommendations Tracker	Audit Tracker to be reviewed in more detail outside of the meeting and discussed as part of the special meeting that would be arranged for the Committee Self-Assessment at the end of August/early September 2019. Audit Committee Chair to write to individual Senior Managers about these matters to coincide with the circulation of the agreed Practice Note.	September 2019	Interim Board Secretary Chair of Audit Committee	**Completed** Meeting held on 3 September to discuss high risk recommendations **Completed**
19/103	15/07/ 2019	Financial Control Procedure Medical Variable Pay	Matter to be escalated to the Executive Team due to the concerns raised in relation to the high levels of Agency Locum Costs. Update to be provided to the October Audit Committee meeting	October 2019	Director of Finance	**In progress** The Medical Director, working with the Director of Workforce and the Director of Finance, has agreed to lead an enabling programme of work around management of temporary medical staffing. This will incorporate the development of a revised FCP. A plan for this work will be brought to the next Efficiency, Productivity and Value Board in November. Internal Audit are also commencing parallel reviews on controls regarding medical agency,

NO.	MEETING DATE	SUBJECT	ACTION	TIMESCALE	RESPONSIBLE OFFICER	STATUS AS AT October 2019
						ADHs, and medical staff rostering.
19/104	15/07/ 2019	Clinical Audit Forward Plan 2019 – 2020	Clinical Audit Forward Plan 2019 – 2020 to be referred to the Quality, Safety & Risk Committee	October 2019		**Completed** Received at the August Quality, Safety & Risk Committee
19/105	15/07/ 2019	Charitable Funds Balances	Members discussed whether a new Charitable Funds would now be required and **AGREED** that a meeting should be held with Independent Member Trustees and the Director of Finance to discuss prior to the next Trustees Meeting. Members **AGREED** that the Health Board Chair would need to be briefed.	October 2019	Director of Finance	**In progress** Annual Trustees meeting to be held on 28 November 2019
19/106	15/07/ 2019	Internal Audit Review – Water Safety	Report to be shared with the Quality, Safety & Risk Committee for information. Further update to be received at the October meeting.	October 2019	Interim Board Secretary	**In progress** Report added to the agenda for the November meeting
19/106	15/07/ 2019	Internal Audit Review – Prince Charles Hospital Redevelopment	Audit Committee Chair to write to the Director of Planning and Performance expressing how pleased the Committee were that all actions had been fully implemented.	October 2019	Audit Committee Chair	**Completed**

AGENDA ITEM
2.1

AUDIT COMMITTEE

2019-2020 POST PAYMENT VERIFICATION MID-YEAR REPORT

Date of meeting	(24/10/2019)
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Scott Lavender
Presented by	Scott Lavender
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The report is capturing 6 months of Post Payment Verification visits for the financial year 2019-2020 and covers Medical, Ophthalmic and Pharmaceutical services.

1.2 In the new format of report we are capturing the history of a practice of the course of their current visit and two historical pre-ceding visits to demonstrate levels of performance over a longer time period, new report at **Appendix 1**, **Appendix 3** and **Appendix 5.**

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The report is provided to the committee for review and assurance.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Historically the team have run both Medical and Ophthalmic training events for contractors and we are about to undertake a new Ophthalmic training event to capture new contractors within the Health Board from Bridgend and also for new premises.

3.2 The new traffic light system that has been implemented into the report is a measure of the risk Post Payment Verification feel necessary to each file. It then allows us to review in collaboration with Primary Care and decide on appropriate follow up actions.

3.3 The PPV Risk Analyst also spends time collating and reviewing large amounts of data and trends analysis to ensure that we give deeper consideration to claiming patterns and history within the practice.

3.4 All of the above changes have been made within Post Payment Verification with the view to providing a more interactive, intuitive streamlined service and to provide assurance of data capture and more efficient ways of working.

3.5 Overall within the report it is highlighted that error rates and recovery amounts are decreasing which is evidence of the positive work that Post Payment Verification and Primary Care are undertaking with contractors.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below)
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Main Strategic Objective	To ensure good value based health care and treatment for our patients in line with the resources made available to the Health Board
Link to Main WBFG Act Objective	Work with communities to prevent ill-health, protect good health and promote better health and well-being

5. RECOMMENDATION

5.1 The Audit Committee is asked to **NOTE** the report.

Cwm Taf Morgannwg University Health Board

Medical PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	9.86%
2019/20 recovery amount	£2,285.21

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	4/28/2016	Extended	31.91%	£7,592.82	2/16/2018	Revisit	38.30%	£10,386.98	4/15/2019	Routine	207	27
Practice 2	12/15/2015	Routine	2.65%	£226.50	6/29/2017	Revisit	8.10%	£986.39	5/31/2019	Routine		
Practice 3	7/9/2012	Routine	0.00%	£0.00	8/11/2015	Routine	1.55%	£5.44	5/21/2019	Routine	134	9
Practice 4	9/11/2013	Routine	4.00%	£125.20	10/24/2016	Routine	3.61%	£49.71		Extended		
Practice 5	4/20/2015	Routine	18.15%	£2,567.87	4/18/2016	Revisit	17.65%	£914.40	7/19/2019	Routine	343	24
Practice 6	11/30/2012	Routine	5.78%	£280.83	5/19/2015	Routine	0.00%	£0.00	7/15/2019	Routine	256	9
Practice 7	8/10/2016	Routine	5.04%	£324.88	2/14/2018	Revisit	0.00%	£0.00	8/19/2019	Routine		
Practice 8	2/12/2014	Revisit	10.58%	£7,742.99	7/3/2018	Routine	13.71%	£1,697.76	9/27/2019	Revisit		
Practice 9	5/20/2014	Routine	0.89%	£23.49	5/16/2017	Routine	1.26%	£1,531.39	5/24/2019	Revisit	39	8
Practice 10	12/5/2011	Routine	9.33%	£1,816.44	4/6/2016	Routine	1.89%	£138.00	8/5/2019	Routine		
Practice 11	4/17/2013	Routine	1.79%	£33.86	6/13/2016	Routine	1.23%	£98.60	9/16/2019	Routine		
Practice 12	10/16/2017	Routine	5.88%	£76.15					9/24/2019	Revisit		
Practice 13	3/1/2017	Routine	3.13%	£100.08					5/8/2019	Routine		
Practice 14									5/8/2019	Revisit	786	97

Claim error %	Recovery
2.42%	£328.93
6.72%	£265.06
7.00%	£637.99
3.52%	£156.00
20.51%	£242.80
12.34%	£654.43

	Health Board			All Wales		
	2017/2018	2018/2019	2019/2020	2017/2018	2018/2019	2019/2020
Number of practices visited	20	19	6	192	216	
Amount of claims sampled	4,846	6,805	1765	106,579	93,772	
Claim errors identified	405	489	174	9,969	7,585	
Average admin error rate	**4.99%**	**4.93%**	**TBC**	**9.75%**	**4.51%**	
Average claim error rate	**8.36%**	**7.19%**	**9.86%**	**9.35%**	**8.09%**	
Recovery amount	£21,577.44	£18,855.66	£2,285.21	£223,134.59	£221,993.26	

Key report points:
In the visit cycle we have only had two practice trigger the red rating and both of those were re-visits which you would anticipate having higher errors as part of the sample covers a period of time where initial errors were identified.
The PPV team have been delivering support and guidance to the practices on completion of visits and also have been offering one-to-one training to practices if they feel they need extra support.
We have had good communication with Primary Care and Counter Fraud surrounding our work and they receive copies of every report we produce for practices to remain well informed.
The Health Board remain under the All Wales claim error rate which shows they are performing better than the national average.

Cwm Taf Morgannwg University Health Board

Ophthalmic PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	7.41%
2019/20 recovery amount	£2,239.30

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	12/9/2015	Routine	2.00%	£80.00	12/12/2018	Routine	0.97%	£20.20		Routine		
Practice 2	5/18/2017	Routine	6.00%	£208.80	4/30/2018	Revisit	9.67%	£1,084.20	6/21/2019	Routine	103	1
Practice 3	11/14/2014	Routine	2.00%	£57.50	4/19/2018	Routine	6.00%	£198.10	7/3/2019	Revisit	300	59
Practice 4	10/15/2012	Routine	1.00%	£152.10	6/21/2016	Routine	4.00%	£149.60	7/25/2019	Routine	103	0
Practice 5									8/13/2019	Routine	103	1
Practice 6	9/14/2017	Routine	10.00%	£225.30	3/4/2019	Revisit	12.33%	£1,286.20	5/22/2019	Routine	103	2
Practice 7	1/7/2015	Routine	0.00%	£0.00	1/16/2018	Routine	3.00%	£181.80	6/18/2019	Revisit	300	12

Claim error %	Recovery
0.97%	£61.20
19.67%	£1,482.15
0.00%	£0.00
0.97%	£61.20
1.94%	£113.15
4.00%	£521.60

Health Board	Year	GOS 3	GOS 4	EHEW
Cwm Taf Morgannwg	2018/2019	3	12	59
	2017/2018	31	0	74

	Health Board			All Wales		
	2017/2018	2018/2019	2019/2020	2017/2018	2018/2019	2019/2020
Number of practices visited	11	13	6	172	141	
Amount of claims sampled	1,500	2,037	1012	22,083	17,780	
Claim errors identified	106	76	75	1,342	1,080	
Average admin error rate	**5.27%**	**17.98%**	TBC	**7.37%**	**4.35%**	
Average claim error rate	**7.07%**	**3.73%**	**7.41%**	**5.74%**	**5.73%**	
Recovery amount	£3,852.80	£2,869.65	£2,239.30	£54,640.34	£36,349.55	

Key report points:
As with GMS a low number of practices have a red rating, only one, and that was a revisit which would have highlighted issues we would have suspected to arise. Support and guidance issued following the visit.
The Health Board claim error rate percentage is sat below the national average which is pleasing and shows good progress.
The administrative error rate is high compared to the national average and we have been providing advice to contractors and have the capabilities to deliver training.
The recovery amount is dropping every financial year which is pleasing to see and we would hope that will continue long term.

Cwm Taf Morgannwg University Health Board

Pharmacy PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	1.20%
2019/20 recovery amount	£364.00

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	3/17/2017	Routine	5.49%	£103.88	6/6/2018	Revisit	0.00%	£0.00	4/17/2019	Routine	90	0
Practice 2	2/15/2017	Routine	2.63%	£56.00					4/17/2019	Routine	58	0
Practice 3	7/4/2016	Routine	0.85%	£0.00					4/2/2019	Routine	87	1
Practice 4	7/1/2016	Routine	0.00%	£0.00					4/2/2019	Routine	54	1
Practice 5	3/17/2017	Routine	0.00%	£0.00					5/1/2019	Routine	100	0
Practice 6	2/6/2017	Routine	1.00%	£28.00					5/1/2019	Routine	100	0
Practice 7	11/18/2016	Routine	1.04%	£28.00					6/19/2019	Routine	97	0
Practice 8									6/19/2019	Routine	50	0
Practice 9	12/9/2016	Routine	0.00%	£0.00					7/4/2019	Routine	92	0
Practice 10	3/9/2016	Routine	0.00%	£0.00	8/29/2017	Routine	0.00%	£0.00	7/4/2019	Routine	57	0
Practice 11	2/15/2017	Routine	4.55%	£84.00					8/27/2019	Routine		
Practice 12	2/6/2017	Routine	5.10%	£140.00					8/27/2019	Routine	95	0
Practice 13	2/1/2017	Routine	2.27%	£56.00					9/10/2019	Routine		
Practice 14	9/9/2016	Routine	0.00%	£0.00					9/10/2019	Routine		
Practice 15	3/20/2017	Routine	3.92%	£43.96					9/16/2019	Routine		
Practice 16					7/18/2018	Routine	7.66%	£560.00	6/24/2019	Routine	100	1
Practice 17	3/20/2017	Routine	2.00%	£56.00					9/2/2019	Routine		
Practice 18	1/20/2017	Routine	11.11%	£15.96					6/24/2019	Routine	100	10
Practice 19	7/20/2017	Routine	17.50%	£392.00					9/26/2019	Revisit		

Claim error %	Recovery
0.00%	£0.00
0.00%	£0.00
1.15%	£28.00
1.85%	£28.00
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
1.00%	£28.00
10.00%	£280.00

Health Board	Year	MUR	Flu
Cwm Taf Morgannwg	2018/2019	14	0
	2017/2018	36	1

	Health Board			All Wales	
	2017/2018	2018/2019	2019/2020	2017/2018	2018/2019
Number of practices visited	27	26	13	298	230
Amount of claims sampled	2,225	2,058	1,030	22,976	18,570
Claim errors identified	37	14	13	520	845
Average admin error rate	**16.11%**	**7.50%**	TBC	**16.86%**	**16.16%**
Average claim error rate	**1.66%**	**0.68%**	**1.26%**	**2.26%**	**4.55%**
Recovery amount	£1,023.96	£392.00	£364.00	£14,079.99	£20,003.71

Key report points:
There is one practice sat in a red rating following a routine visit, this has triggered a revisit with the issues, we have provided guidance to the contractor and will re-iterate at the next visit to en
Overall the Health Board is performing well below the national average which shows progressiv
The administrative errors have dropped significantly over the financial years which is very pleas so we would expect to see more improvement moving forward.

2019/2020

in 12 months to further review nsure improvement.
ve improvements.
sing, it is sat at an amber rating

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**Reference Number: OP2** **Version Number: 3** **Next Review date: 00/00/00** **To Be confirmed following Audit Committee approval**

COUNTER FRAUD BRIBERY AND CORRUPTION POLICY AND RESPONSE PLAN

Introduction

This document sets out the Health Board's policy and response plan for detected or suspected economic crime.

Objectives

This document is intended to raise awareness of the risk of economic crime within the NHS, and to provide direction and help to all staff, Officers and Directors who identify and/or find themselves having to deal with suspected cases of economic crime.

It gives a framework for a response, and advice and information on various aspects and implications of an investigation.

Operational Date	**Expiry Date**
00/00/0000 **To be confirmed following Audit Committee approval**	**Formal** – three years **Informal** – one year

Scope

This policy applies to all staff on all locations across the Health Board and its hosted bodies.

Equality Impact Assessment	This Policy has been subject to an equality assessment, and no impact has been identified.
Distribution	All staff via internet and team briefings.
To be read by	All Staff
Documents to read alongside this Policy	Standards of Behaviour Policy Disciplinary Policy and Procedure Procedure for NHS Staff to Raise Concerns

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Approved by	Audit Committee
Accountable Executive / Lead Director (responsible for formal review every three years)	Director of Finance
Author / Management Lead (carries out informal review annually)	Head of Local Counter Fraud Services
Freedom of Information Status	Open

If the review date of this policy has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Services Department.

To avoid use of out of date policies please do not print and then store hard copy of this document.

Out of date policies cannot be relied upon.

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1. Purpose

1.1 One of the basic operational principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work for Cwm Taf Morgannwg University Health Board (CTMUHB) are aware of the risk of, and measures put in place to deal with, fraud, bribery and corruption, and other illegal acts involving dishonesty or loss. For simplicity all such offences are hereafter referred to as "economic crime", except where the context indicates otherwise. This document sets out the Health Board's policy and response plan for detected or suspected economic crime.

1.2 This document is intended to provide direction and help to all staff, Officers and Directors who identify and/or find themselves having to deal with suspected cases of economic crime. It gives a framework for a response, and advice and information on various aspects and implications of an investigation. This document is not intended to provide direction on prevention of economic crime, but will:

- improve the knowledge and understanding of everyone in the CTMUHB, irrespective of their position, regarding the risk of economic crime and its unacceptability
- assist in promoting a climate of openness, and an environment where staff feel able to raise legitimately held concerns with confidence that they will be dealt with in a professional manner.
- set out the CTMUHB's strategy in terms of the deterrence, prevention, detection and investigation of economic crime.

1.3 This Policy should be read in conjunction with the CTMUHB's Disciplinary Policy, Standards of Behavior Policy and Procedure for NHS Staff to Raise Concerns.

2. Policy Statement

2.1 Cwm Taf Morgannwg UHB **will not tolerate** economic crime and is committed to reducing levels to an absolute minimum, and keeping them there, thus freeing up valuable resources to be used in the provision of high quality patient care.

2.2 The Health Board is committed to the rigorous investigation of all reported cases of potential economic crime. Where criminality is proven, the appropriate disciplinary, regulatory, civil and/or criminal sanctions will be pursued, and where possible, recovery of any losses to the organisation or wider NHS will be sought.

2.3 The organisation wishes to encourage anyone having reasonable suspicions that an economic crime may have been committed to report them. It is the CTMUHB's policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting such concerns.

2.4 Similarly, this Health Board has a duty to protect individuals and the organisation from false, malicious or vexatious expressions of concern. Action may be taken against anyone who is found to have:

- Made allegations falsely or maliciously
- Externally disclosed information before or instead of using the appropriate established internal procedures.
- Victimised or deterred anyone from raising a concern.

2.5 All genuine suspicions or concerns regarding economic crime can be reported in the following ways:

- To the Health Board Local Counter Fraud Specialist
- To the Director of Finance
- Via the NHS Fraud and Corruption Reporting Line on **0800 028 40 60**
- Using the online reporting tool at https://cfa.nhs.uk/reportfraud

2.6 This policy is supported and endorsed by the Cwm Taf Morgannwg UHB Audit Committee, and by the Board.

3. Principles

3.1 Cwm Taf Morgannwg UHB is committed to taking a holistic approach to tackling the risks of economic crime within the organisation, via the implementation of action in the following areas:

The creation of an anti-economic crime culture
Sending a clear message that economic crime will not be tolerated, raising awareness of its risks and consequences, and informing staff about how they can raise concerns. Developing a strong anti-economic crime culture within the organisation underpins all other work undertaken, and is closely linked to the creation of a strong deterrent effect.

Maximising the deterrence of economic crime
Discouraging individuals who may be tempted to commit economic crime against the NHS from doing so in the first place. Raising aware of the existence and role of the LCFS, together with effectively publicising successful sanctions and redress both play a significant part in this process.

Preventing economic crime which cannot be deterred
The Board has already put measures in place that reduce the likelihood of economic crime occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and systems of internal control and risk assessment. In addition, where further potential risks or weaknesses are identified, the LCFS will work with staff to identify and implement improved policies, procedures, systems and controls.

Prompt detection of economic crime which is not prevented
Proactive investigation, testing and review is undertaken within identified risk areas by both the LCFS and NWSSP Audit & Assurance colleagues. In addition, the UHB takes part in the National Fraud Initiative, a biennial exercise designed to assist in the detection of fraudulent and/or erroneous payments from the public purse.

Professional investigation of detected economic crime
The Health Board is committed to ensuring the thorough, impartial and professional investigation of all allocated economic crime allegations and concerns, which are conducted in line with all relevant legislation, policies and guidance.

Pursuit of appropriate sanctions
The Health Board is committed to the consistent pursuit of the full range of available sanctions against those found to have committed economic crime, in line with the NHS Counter Fraud Authority policy document 'Applying Appropriate Sanctions Consistently'.

Application of effective methods of seeking redress
Redress allows economic crime losses to be returned to the organisation for use as intended i.e. for the provision of high quality patient care. Wherever appropriate, the Health Board will seek to recover all identified losses resulting from proven economic crime, having due regard to the particular circumstances of each case.

3.2 In addition, the Seven Principles of Public Life (The Nolan Principles), which are fully supported by the Board, integrate all aspects of governance and embody the values and standards of behavior expected of all UHB employees. Their adoption and practical implementation also form the basis of the creation of an effective anti-economic crime culture:

Selflessness
Individuals should act solely in the interests of patients and the public. They should not do so in order to gain financial or other benefits for themselves, their family or friends

Integrity
Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their duties

Objectivity
In carrying out their duties, all decision and choices should be based on merit

Accountability
Everything done by those who work in the NHS in Wales must be able to stand the tests of Welsh Government scrutiny, public judgments on propriety and professional codes of conduct

Openness
The organisation's activities should be sufficiently public and transparent to promote confidence between the organisation and its patients, staff and the public. Individuals should be as open as possible about all the decisions and actions they take, and their reasons

Honesty
There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales; integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties. Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest

Leadership
Individuals should promote and support these principles by leadership and example.

3.3 The Health Board's Standards of Behavior Policy echoes and elaborates on the above principles, giving clear guidance to staff on the standards expected of them in the discharge of their duties in key areas including:

- Declarations of interests
- Gifts, hospitality and sponsorship
- Secondary employment and private practice
- Participation in procurement exercises

4. Scope

4.1 This Policy is applicable across the whole of the Health Board. It applies to all employees and Independent Board Members. The term "employees" includes all those who have a contract of employment or honorary contract with the Health Board.

4.2 The Policy is equally applicable to any hosted bodies and their employees.

5. Legislative and NHS Requirements

5.1 It is the policy of the organisation to comply with all relevant NHS, UK and EU mandatory, statutory and legislative requirements in relation to the development and implementation of its counter fraud policy and response plan. Key areas which must be considered include, but are not limited to:

- Fraud Act 2006
- Bribery Act 2010
- Criminal Procedures and Investigations Act 1996
- Police And Criminal Evidence Act 1984
- Data Protection Act 2018
- Human Rights Act 1998
- Regulation of Investigatory Powers Act 2000
- NHS Counter Fraud Manual

6. Roles and Responsibilities

6.1 Chief Executive

6.1.1 The Chief Executive has overall executive responsibility for the activities of the UHB; is responsible to the Chair and the Board for ensuring that financial obligations and targets are met; and has overall responsibility for the system of internal control.

6.1.2 In doing so, the Chief Executive has overall responsibility for ensuring compliance with Directions on fraud, bribery and corruption issued by the Welsh Government.

6.2 Director of Finance

6.2.1 The Director of Finance is responsible for maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of

separation of duties and internal checks are prepared, documented and maintained.

6.2.2 In doing so, the Director of Finance has operational responsibility for monitoring and ensuring compliance with Welsh Government Directions, and ensuring that action to counter economic crime is in accordance with the NHS Counter Fraud Manual and Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

6.2.3 The Director of Finance shall inform and consult with the Chief Executive at the first opportunity in all cases where losses resulting from economic crime may exceed the delegated limit (or such lower limit as the UHB Board may determine) or where the incident may lead to adverse publicity.

6.2.4 In cases where investigations have found evidence that an economic crime has potentially been committed, the Director of Finance must review the case with the LCFS and give formal authority to prosecute before a file can be passed to the Crown Prosecution Service (CPS) for a charging decision.

6.2.5 The Director of Finance is responsible for ensuring that all losses are properly managed in accordance with the guidance contained within the Welsh Government's Manual of Accounts, as set out in Standing Financial Instructions. In cases of economic crime, or of anomalies which may indicate economic crime, the Director of Finance must inform the LCFS, the NHS Counter Fraud Service Wales and NHS Counter Fraud Authority, in accordance with Directions issued by Welsh Ministers on fraud and corruption.

6.2.6 The Director of Finance shall liaise with the NHS Counter Fraud Service Wales and/or Local Counter Fraud Specialist before any decision is taken on the referral of a case of economic crime to the Police or any other external body for assistance or investigative action.

6.2.7 The Director of Finance is responsible for ensuring that the UHB seeks financial redress in respect of losses incurred where appropriate.

6.3 Audit & Assurance Services

6.3.1 NHS Wales Shared Services Partnership (NWSSP) Audit & Assurance Services will ensure that due regard is given to the possibility of economic crime and other irregularities as part of their work, and will seek to identify weaknesses in control that could permit economic crime or other irregularity to occur.

6.3.2 Where such weaknesses are identified, or where a suspicion or evidence of potential economic crime is highlighted, this will be immediately reported to the Lead LCFS.

6.3.3 In any event, Audit & Assurance Services will share information and intelligence with Local Counter Fraud Services in line with the agreed Information Sharing Protocol.

6.4 Workforce & Organisational Development

6.4.1 Workforce & Organisational Development staff (W&OD) will liaise closely with managers and the LCFS if an employee is suspected of being involved in economic crime. Whilst this close liaison is essential in ensuring that parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner, the timing and content of any information exchanged will be critical, and so will be judged on a case-by-case basis in accordance with agreed liaison protocols.

6.4.2 W&OD staff shall advise those involved in an investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as required.

6.4.3 Where a member of staff is to be interviewed under caution the Local Counter Fraud Specialist shall consult and liaise with W&OD and/or the relevant departmental head. **Interviews under caution must only be conducted by the Local Counter Fraud Specialist.**

6.5 Local Counter Fraud Specialist

6.5.1 Local Counter Fraud Specialists (LCFS) are appointed by and report directly to the Director of Finance, and are the primary point of contact for all economic crime concerns within each health body. They are professionally trained and accredited, and equipped to respond to any concerns raised by staff.

6.5.2 The work of the LCFS is closely aligned to the day-to-day implementation of action under the four Key Principles of economic crime activity:

- Strategic Governance
- Inform & Involve
- Prevent & Deter
- Hold to Account

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6.5.3 The LCFS will produce an annual risk-based work plan at the beginning of each financial year, detailing planned activity under each of these four Key Principles. Progress is reported to and monitored by the Director of Finance and Audit Committee.

6.5.4 The LCFS is responsible for the thorough, impartial and professional investigation of all allocated economic crime allegations and concerns, which are conducted in line with all relevant legislation, policies and guidance. In doing so, the LCFS will ensure that the Director of Finance and Counter Fraud Service Wales are informed about all such referrals received, and are regularly updated on action and progress.

6.6 CTMUHB Staff

6.6.1 Staff are required to comply with all relevant Health Board policies and procedures, and apply best practice in order to prevent fraud, bribery and corruption which may affect the organisation.

6.6.2 Staff have a duty to protect the assets of the CTMUHB, including information and goodwill as well as property, and to notify the LCFS of any suspected economic crime. Staff are protected by this policy as well as the UHB Procedure for NHS Staff to Raise Concerns in all cases where suspicions are genuinely raised.

6.6.3 In addition to making a direct report to the LCFS or Director of Finance, suspected NHS economic crime can also be reported in the following ways:

- Via the NHS Fraud and Corruption Reporting Line on
- **0800 028 40 60**
- On-line at https://cfa.nhs.uk/reportfraud

6.7 CTMUHB Management

6.7.1 Over and above the staff responsibilities detailed above, those in management positions are also responsible for ensuring:

- Effective communication and consistent application of all relevant policies and procedures (including this one) within the areas for which they are responsible.
- The implementation of effective systems, processes and controls designed to reduce the risk of economic crime to a minimum
- The promotion of an anti-economic crime culture within their area(s) of responsibility, raising awareness of the risk of economic crime with their staff

- Ensuring that staff are aware of the correct course of action should they have a concern (i.e. contact the LCFS).

6.7.2 All instances of actual or suspected economic crime which come to the attention of a manager must be reported immediately. It is appreciated that some employees may initially raise concerns with their manager; however in such cases, managers must not attempt to investigate the allegation themselves. They have a clear responsibility to refer the concern to the LCFS as soon as possible.

6.7.3 Managers have a responsibility to ensure that the LCFS or other persons authorised to carry out investigations have access, as soon as is practical, to premises, records, data and staff who may have relevant information.

6.7.4 Managers should ensure that employees are aware that the LCFS will routinely examine information in the course of their duties, e.g. claims for travel expenses, overtime claims, attendance records, work rotas and other documents.

7. WHAT IS FRAUD?

7.1 Fraud is a criminal activity, defined as:
"*Abuse of position, or false representation, or prejudicing someone's rights for personal gain*"

Serious Fraud Office (SFO)

Put simply, fraud is an act of dishonesty with the intention of making a gain, or causing a loss to another party.

7.2 The Fraud Act 2006 created a general offence of fraud, which can primarily be committed in three ways:

a) Fraud by false representation (s.2) – being untruthful about something using any means, e.g. by words or actions

b) Fraud by failing to disclose information (s.3) – not disclosing/saying something when you have a legal duty to do so
c) Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

In addition, the Act also created offences relating to the making or supply of article for use in fraud.

7.3 It is no longer necessary to prove that a person has been deceived; the focus is now on the dishonest behaviour of the subject. It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed **dishonestly** and with **intent** to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there.

8. WHAT IS BRIBERY?

8.1 The Bribery Act 2010 came into force on 1st July 2011, reforming the criminal law of bribery and making it easier to tackle the offence in both the public and private sectors.

8.2 Broadly, the Act defines bribery as offering, giving, requesting or receiving a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

8.3 The Act creates two general bribery offences, concerned with bribing another person or giving bribes (the active offence), and being bribed or receiving bribes (the passive offence).

Bribing another Person (s.1) – To offer, promise or give a financial or other advantage to another person either intending to induce or reward improper performance, or knowing or believing acceptance of the advantage constitutes improper performance.

Being Bribed (s.2) – To request, agree to receive or accept a financial or other advantage:

- Intending that as a consequence, a function or activity should be performed improperly

  Or

- Where the request, agreement, or acceptance itself would constitute improper performance of a function or activity

  Or

- As a reward for the improper performance of a function or activity which has already occurred

8.4 The Act also introduces a new offence of failure on the part of a commercial organisation to prevent bribery being committed in connection with its business. An organisation will have a full defence against this offence if it can show that, despite a particular case of bribery, it nevertheless had adequate procedures in place to prevent persons associated with it from undertaking such conduct.

9. THE RESPONSE PLAN

9.1 Introduction

9.1.1 The following narrative describes the CTMUHB's intended response to a reported suspicion of economic crime. It outlines procedures which allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal, disciplinary or civil action. The narrative has also been summarised in a series of process charts included at Appendix 1.

9.1.2 Each case is different; it is not possible to cover all of the situations and complexities which can arise during the course of an investigation. The exact processes followed will therefore need to be considered carefully in relation to the actual circumstances of the matter under investigation before action is taken. In some cases, e.g. if a major diversion of funds is suspected, speed of response may be crucial to minimise or avoid financial loss.

9.1.3 The NHS Counter Fraud Authority (CFA) has a range of information sharing agreements and memorandum of understanding in place with key stakeholders. These provide a framework for the exchange of information for the prevention, detection, investigation and prosecution of economic crime matters, and are intended to facilitate good working relationships and clear lines of communication between all parties.

9.2 Aim of the Response Plan

9.2.1 The aim of the Response Plan is to have measures in place to respond professionally and appropriately to any alleged economic crime against the Health Board or wider NHS. Its purpose is to -

(a) Minimise the risk of subsequent losses;

(b) Maximise the chance and scale of recoveries;

(c) Identify the parties involved;

(d) Demonstrate that the UHB retains control of its affairs in a crisis, thereby minimising any adverse publicity;

(e) Make a clear statement to employees and other parties that the organisation is not a soft target for attempted economic crime.

(f) Identify weaknesses and lessons learned for the future.

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9.3 REPORTING FRAUD

9.3.1 If someone suspects that an economic crime has been perpetrated against the organisation or wider NHS, or by one of its employees, they must report it immediately using one of the following options:

- In the first instance, it is recommended that they contact the Local Counter Fraud Specialist or Director of Finance.
- Alternatively, for example if the LCFS or Director of Finance may be implicated in the concern, they can call the NHS Fraud and Corruption Reporting Line on free phone **0800 028 40 60**. This provides an easily accessible route for the reporting of genuine suspicions of economic crime within or affecting the NHS. It allows those who do not wish to use the internal reporting mechanisms to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.
- Or online at https://cfa.nhs.uk/reportfraud

9.3.2 Contact can also be made with the charity Public Concern at Work on 020 7404 6609. They are able to provide additional advice on how to go about raising matters of concern in the appropriate way.

9.3.3 Anonymous letters, telephone calls, etc. are also sometimes received from individuals who wish to raise matters of concern. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

9.3.4 If an economic crime is suspected, it is essential that there is the earliest possible consultation with the Local Counter Fraud Specialist before any overt action is taken which may alert suspects or result in the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.

9.3.5 The LCFS will make sufficient initial enquiries to establish whether or not there is any foundation to the concern that has been raised. If it is found that there is no basis to the concern (for example, the result of a simple misunderstanding of circumstances), the LCFS will complete a closure report and the matter will be closed. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

9.3.6 Where these initial enquiries do find cause for concern, the Operational Fraud Manager for Wales will allocate the matter for preliminary investigation.

9.3.7 A record will be retained of all reported suspicions, including those dismissed as minor or otherwise not investigated. It will also contain details of actions taken and conclusions reached.

9.3.8 Instances of theft or damage to CTMUHB or personal property should be reported to the Police at the earliest opportunity on every occasion.

9.4 MANAGING THE PRELIMINARY INVESTIGATION

9.4.1 Where there are grounds to suspect that an economic crime may have occurred, the Operational Fraud Manager for Wales will allocate the case for preliminary investigation by either the LCFS or the Counter Fraud Service Wales Team.

9.4.2 At the outset (and throughout any investigation), the LCFS and/or CFS Wales will ensure that appropriate communication is maintained with the Director of Finance, and any other party deemed necessary, in order to ensure that they are appropriately appraised on the progress and findings.

9.4.3 The following, whilst not intended to be exhaustive, outlines some of the initial issues to be considered as part of the preliminary investigation process:

(a) Where the allegation relates to a Health Board employee, immediate consideration should be given to the need to suspend or redeploy the individual(s) concerned.

(b) The need to address any system weaknesses identified, to remove the possibility of further economic crime being committed against the CTMUHB, and the timing of such action.

(c) The preparation of background or objective statements, outlining the nature of the suspected incident.

(d) The LCFS overseeing the investigation should initiate an action plan with clearly identified objectives, and a Case Progress Sheet should be kept in order to record the progress of the investigation.

(e) The implementation of procedures for preserving evidence.

(f) Ensure that proper arrangements are in place for undertaking and formally recording witness statements and interviews in a manner that would be acceptable to the Courts.

(g) Estimate and monitor the costs of the investigation (if appropriate)

(h) Maintain regular contact to discuss progress and the likely outcome with the Director of Finance and any other relevant parties.

9.4.4 Where the findings of the preliminary investigation indicate that an economic crime has taken place and this is allocated for local investigation, the process of taking witness statements and gathering evidence will then be progressed by the Local Counter Fraud Specialist in line with Section 9.5 (Chart 3).

9.4.5 Should the investigation find insufficient or no evidence that a criminal act has taken place; the LCFS will complete a Preliminary Outcome of Investigation Report detailing those findings, together with any recommendations considered necessary to address system weaknesses highlighted. The next step should then be to determine what (if any) further action is considered necessary. This may include one or all of the following:

- Internal (Health Board) disciplinary investigation
- Referral to the appropriate professional/member body
- Civil proceedings or recovery of any identified loss.

9.4.6 Where appropriate, the LCFS will assist with any further action(s) considered necessary. This will include sharing the findings of the criminal investigation where it is lawful to do so.

9.4.7 At their conclusion, the LCFS will be advised of the outcome of all further action(s) taken. The Director of Finance, CFS Wales, and other relevant parties will also be updated as appropriate. The LCFS will then produce a Final Outcome Report, and the case will be closed.

9.5 GATHERING EVIDENCE – WITNESS STATEMENTS AND EXHIBITS

9.5.1 If a witness who has information pertaining to the matter under investigation is prepared to give a written statement, the Local Counter Fraud Specialist will take a chronological record using the witness's own words. The witness should be prepared to sign the document as a true record, and if necessary to appear in court in support of their statement.

9.5.2 In addition to giving a statement a witness may also be in possession of, or be in a position to formally produce, physical evidence or key documents which are germane to the matter under investigation.

9.5.3 The collection of such evidence must be coordinated if more than one party is involved in an investigation (for example if criminal and disciplinary investigations are being conducted side-by-side). Evidence gathering requires skill and experience and professional guidance should be sought where necessary, particularly in relation to evidence stored on or obtained from electronic media. There is considerable case law concerning the admissibility of evidence.

9.5.4 For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act 1984 (PACE). For non-criminal proceedings (i.e. civil or disciplinary), PACE does not apply but should nevertheless be regarded as best practice.

9.5.5 Upon taking control of any physical evidence, it is very important that a written record is made of the time, date, person and place it is taken from, and by whom – continuity is essential. If the evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record.

9.5.6 Witness testimony and evidence gathered will be kept under constant review during the course of an investigation. If, having exhausted all reasonable lines of enquiry, it if felt that there is insufficient evidence to warrant conducting an interview under caution, the matter will be progressed in line with paragraph 9.4.5 and Chart 2 of this Policy.

9.5.7 Alternatively, if it felt that there is sufficient cause, the subject(s) of the investigation will be invited to a voluntary interview under caution. It should be noted that an interview under caution should only be conducted by an accredited and nominated Local Counter Fraud Specialist.

9.5.8 Where the possible use of police powers such as arrest is being considered, for example if a subject has refused to attend for interview, the LCFS will confer with both the Director of Finance and NHS Counter Fraud Service Wales prior to contacting the Police to request assistance.

9.6 INTERVIEW UNDER CAUTION AND FURTHER ENQUIRIES

9.6.1 The requirements of PACE (Police and Criminal Evidence Act 1984) must be considered before and during any interview under caution with a subject, as compliance with the Act determines whether evidence is admissible in criminal proceedings. **Interviews under caution must only be conducted by the LCFS.**

9.6.2 The LCFS will review the account given at interview by the subject and decide what, if any, further investigation is required. In doing so, advice may be taken from the Counter Fraud Service Wales, CPS or any other relevant party. Where the responses obtained during the interview open new lines of enquiry, these must be pursued, and may result in the subject being interviewed again.

9.6.3 Once the LCFS is satisfied that all reasonable lines of enquiry have been pursued and concluded, the full findings of the investigation are reviewed. Typically this process results in one of two outcomes:

- There is insufficient (or no) evidence that a crime has been committed. At this point (if not already commenced), consideration will be given to what other action may be appropriate (civil, disciplinary and/or referral to a professional/member body).
- The investigation has identified clear evidence that an economic crime may have been committed

9.6.4 Where evidence of a potential criminal offence has been identified, a file of evidence will be passed to the Crown Prosecution Service (CPS) for a charging decision. The charging decision returned by the CPS will typically be one of the following:

- The evidence submitted fails to meet the Full Code Test set out in the Code for Crown Prosecutors, and as such, the matter is not suitable for prosecution. At this point (if not already commenced), consideration will be given to what other action may be appropriate (civil, disciplinary and/or referral to a professional/member body).
- The evidence submitted meets the Full Code Test set out in the Code for Crown Prosecutors. A decision will then be made on the most appropriate charge(s), based on the evidence presented.
- The matter would most appropriately be dealt with using an out-of-court disposal, typically via the issue of a simple or conditional caution. In reaching this decision, the CPS must ensure that the appropriate evidential standard is met, and that the public interest would be properly served by such a disposal.
- Further investigation is required before a charging decision can be made. The matter would then be referred back to the LCFS who would complete the additional investigation(s) requested, and submit further evidence to facilitate the charging decision.

9.7 CONCLUSION OF THE INVESTIGATION

9.7.1 At the conclusion of the investigation, and once the outcome of any criminal proceedings and/or other actions are known, the Local Counter Fraud Specialist will produce an Outcome of Investigation

Report. Typically, copies of this report will be provided to the Director of Finance and Operation Fraud Manager for Wales. Summaries (anonymised as/if appropriate) will also be included in activity reports to the Audit Committee.

10. SANCTIONS

10.1 The Health Board is committed to the rigorous investigation of all reported cases of potential economic crime effecting the organisation, and to seeking sanctions wherever appropriate.

10.2 Mechanisms have been put in place to ensure that the investigation of reported economic crime is conducted in a way which ensures that the widest possible range of sanctions remain available throughout the process, and the application of parallel sanctions is always considered.

10.3 It is important to emphasise that whilst the following provides a framework to apply parallel sanctions, it is not prescriptive. The decisions on which methods to apply and when will be made on a case-by-case basis:

a) **Criminal Prosecution -** Where there is evidence that a criminal offence has been committed, the Health Board will work with CFS Wales, the Crown Prosecution Service and where necessary the Police in order to ensure that the most appropriate criminal sanction is applied.

b) **Disciplinary Sanction –** Where it appears that Health Board policies and procedures have been breached or standards of conduct contravened; this will be investigated in line with the Disciplinary Policy & Procedure. Where proven, potential outcomes include verbal or written warnings or, where the employee's actions are considered to be gross misconduct, dismissal.

c) **Professional Body Referral –** Where necessary, a subject's actions may also be referred to their professional body (NMC, GMC, GPHC etc.) for investigation under the terms of their code of conduct or its equivalent. Where proven, potential outcomes include the suspension or removal of the subject from the relevant practitioner register.

10.4 In respect of b) and c) above, where it is appropriate, the LCFS will assist with any investigations undertaken. This will include sharing the findings of the criminal investigation where it is lawful to do so.

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11. REDRESS

11.1 The seeking of financial redress or recovery of losses will always be considered by the Health Board.

11.2 As a general rule, recovery of the loss caused by the perpetrator should always be sought; however it is important to stress that such decisions (as well as decisions relating to the most appropriate method of seeking redress) must be taken in light of the particular circumstances of each case. Where necessary, advice should be sought from CFS Wales and an appropriate Solicitor as part of that process.

11.3 Civil Proceedings - Freezing Orders, Asset Disclosure and Tracing

11.3.1 Redress or recovery can be achieved via a local agreement between the Health Board and the subject to repay monies lost, or through enforcement of a civil order for repayment.

11.3.2 If there is evidence to show that monies or other assets have been misappropriated, and there is a risk of dissipation by the suspected person(s), consideration should be given to applying to the civil courts for injunctive relief without notice to the suspected fraudster. The High Court has the power to grant injunctions 'in all cases in which it appears to the court to be just and convenient to do so' (Section 37 Senior Court Act 1981). A freezing order is an interim order which restrains a party or parties from:

- Removing from the jurisdiction assets which are located there

  Or

- Dealing with any assets, whether located in the jurisdiction or not

Typically the order will be confined to assets within the jurisdiction if they are of sufficient value to match the value of the claim.

11.3.3 An injunction, such as a freezing order, is accompanied by a 'Penal Notice'. This warns the subject that any failure to comply properly or at all with the order may be a contempt of court punishable by sequestration of assets, fine, or in serious cases imprisonment. Further, any person who knows of the order and does anything which helps or permits the subject to breach its terms may also be held in contempt of court, and may be imprisoned, fined, or have their assets seized.

11.3.4 The injunction can also include additional orders to assist the claimant in securing or tracing assets. The provision of information by the subject to the claimant and the Court about property and assets is known as 'asset disclosure'. Information about what has become of property and/or assets (e.g. the subject may have bought a house or shares with misappropriated money, or converted a misappropriated asset onto cash and then purchased another asset with some or all of the sale proceeds) is known as 'tracing information'.

11.3.5 Orders can also be made prohibiting the subject from leaving the jurisdiction for a prescribed period of time, and in appropriate cases compelling him or her to deliver up passports and other travel papers until they provide the asset and/or tracing information.

11.3.6 The standard form of freezing order provides that the subject must give asset disclosure immediately upon being served, and subsequently confirm that information within a certain time limit on affidavit. It should also be noted that third parties in possession or control of funds and/or other assets belonging to the subject who are aware of the freezing order (e.g. banks) are also bound by it.

11.3.7 A freezing order does not by itself give the claimant any property rights over the assets in question. The question of rights is dealt with at the substantive civil proceedings which the order supports. The purpose of the freezing order is purely to prevent the subject from making him or herself judgement-proof (i.e. dealing with or disposing of assets so that if a claimant is successful, there are no assets left to satisfy the judgement).

11.3.8 Freezing orders can be obtained from the civil court 'without notice' and 'in private'. The application is made behind closed doors, without the knowledge of the intended subject and at a hearing that members of the public are not entitled to attend. This helps to protect against the risk that the subject may take action to frustrate a claimant's efforts to secure assets.

11.3.9 Interim injunction orders such as these must be followed by a substantive claim against the subject, which they may admit or defend in the usual way. This means, in practice, that the claimant must be ready to commence the civil claim when the orders are being obtained from the court. The standard form of freezing order contains undertakings to the court that the claimant will serve substantive proceedings (i.e. the claim form) on the subject 'as soon as is practicable', and this is rigorously policed.

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11.4 Criminal Proceedings – Restraint, Confiscation and Compensation

11.4.1 In an appropriate case, the criminal court has the power to impose a restraint order, followed by a confiscation order, on application by the investigator or prosecutor.

11.4.2 Investigators may apply to the Crown Court for a restraint order under Section 40 of the Proceeds of Crime Act 2002 (POCA), provided that a criminal investigation has begun. If there is no such criminal investigation and assets are at risk, a freezing order and any other necessary interim relief must be considered (see Section 11.3).

11.4.3 If criminal proceedings result in a conviction, confiscation proceedings may follow seeking the confiscation of the restrained assets by reference to the benefit the offender has enjoyed from their crime. In certain circumstances, the court will be entitled to assume that the offender has conducted a 'criminal lifestyle', with the result that all assets obtained by them during the preceding 6 years will be subject to confiscation. The burden is on the offender to show, to the civil standard of proof, that those assets have been legitimately acquired.

11.4.4 A confiscation order results in forfeiture by the criminal to the state of the 'benefit' of the crime. The victim (e.g. the health body) will not receive any of the forfeited assets unless they are successful in an application to the court for a compensation order. If the application is successful, the victim will receive all or part of the proceeds of the confiscated assets. In this way the full rigours of the confiscation provisions are brought to bear on the defendant in the recovery of the proceeds of crime, but the end-product of that recovery is paid to the health bodies rather than the treasury.

11.4.5 If the defendant is acquitted or the prosecution dropped, this may – depending on the reason – be grounds for the discharge of the restraint order. If the restraint order is discharged, leaving the defendant free to deal with or dispose of their assets, the onus will be on the victim to seek civil recovery and obtain a freezing order to replace the restraint order.

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12. Training Implications

12.1 Welsh Government Directions require all LCFS to achieve the Accredited Counter Fraud Specialist qualification, as recognised by the Counter Fraud Professional Accreditation Board.

12.2 LCFS are also required to undertake any further training deemed necessary by the Director of Finance, NHS Counter Fraud Authority and/or NHS Counter Fraud Service Wales, and to maintain their CPD.

12.3 There are currently no direct training implications for Cwm Taf Morgannwg UHB staff arising from this Policy and Response Plan. However, LCFS will design and implement a programme of economic crime awareness presentations to be delivered to staff at all levels within the Health Board, with the aim of ensuring that the organisation is proactive in raising awareness and building an anti-economic crime culture.

13. Review, Monitoring & Audit Arrangements

13.1 This Policy and Response Plan will be reviewed by the Head of Local Counter Fraud Services and/or Lead LCFS at least once every three years. An earlier review may be warranted if one or more of the following occurs:

- As a result of regulatory or legislative changes or developments
- Issues highlighted with its operational implementation
- For any other relevant or compelling reason.

13.2 Following review, the Policy and Response Plan will be brought to the Audit Committee for approval.

14. Retention and Archiving

14.1 In cases of complaints / claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Director of Finance and Head of Local Counter Fraud Services will therefore ensure that copies of this policy are archived and stored in line with the Records Management Strategy and are made available for reference purposes should the situation arise.

15. Equality Impact Assessment Statement

15.1 This Policy has been subject to an equality assessment and no impact has been identified.

Appendix A

Counter Fraud Response Plan Process Charts

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CHART 1 – Reporting a Suspicion or Concern

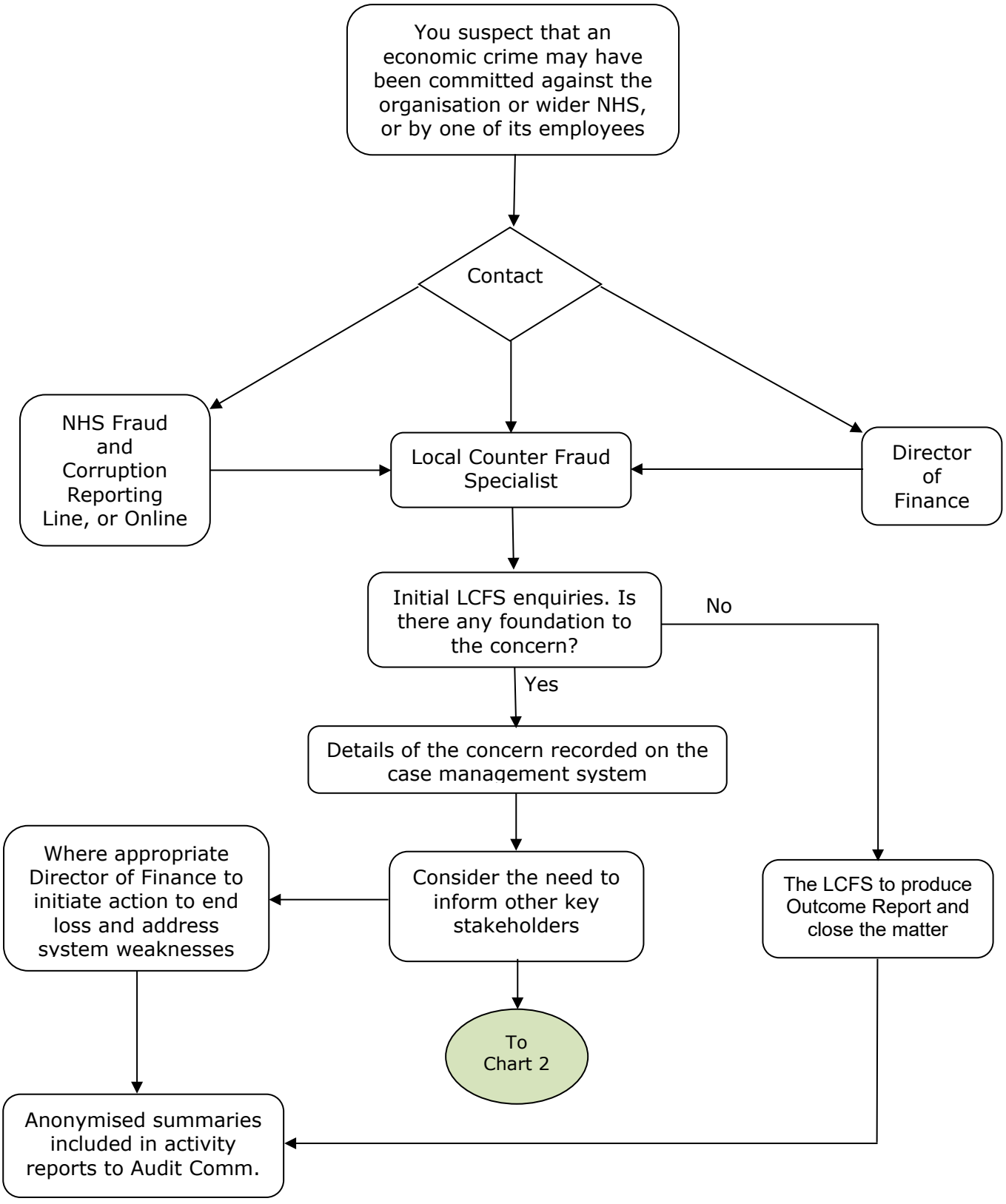
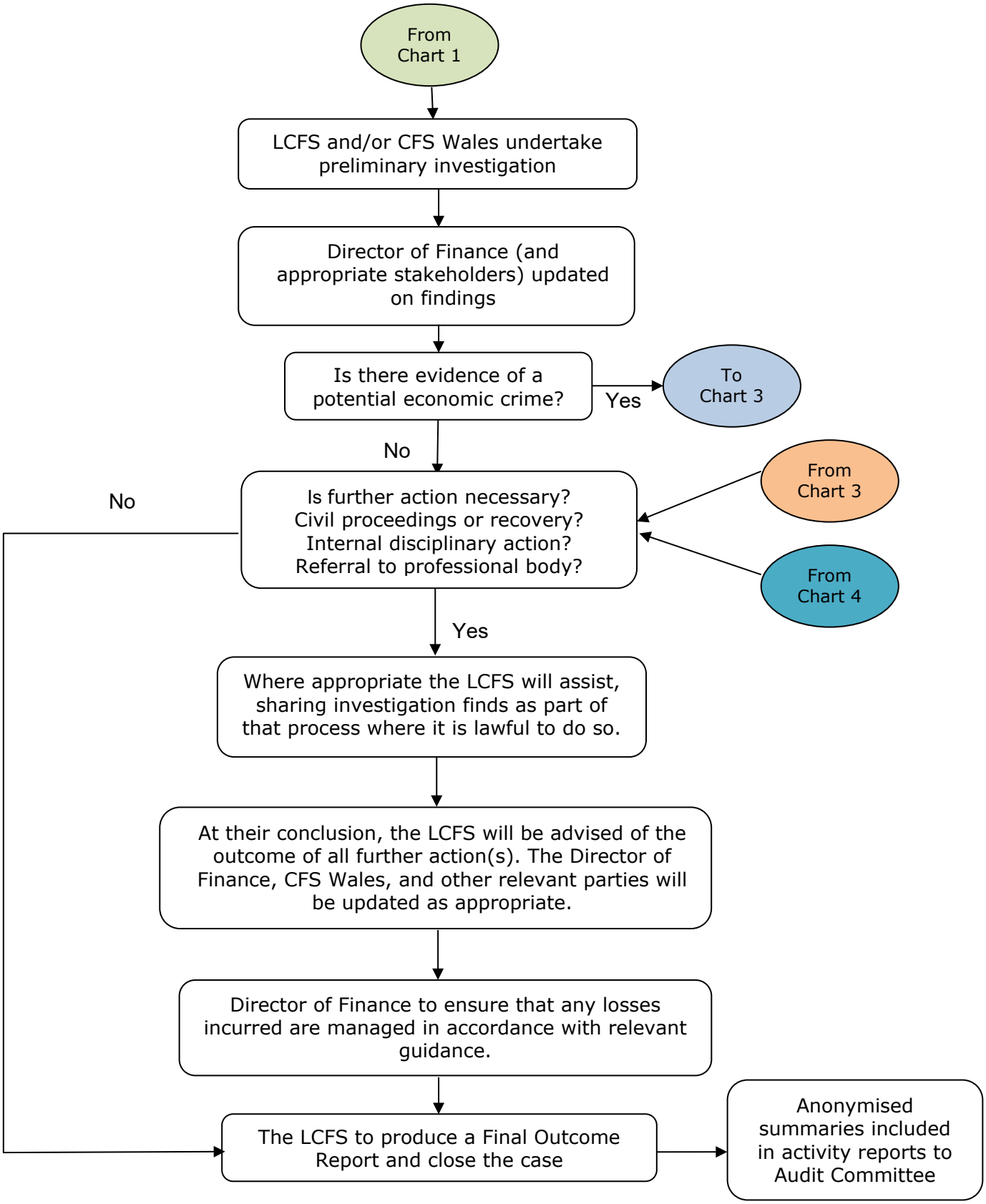


CHART 2 - Managing the Preliminary Investigation



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CHART 3 – Gathering Evidence

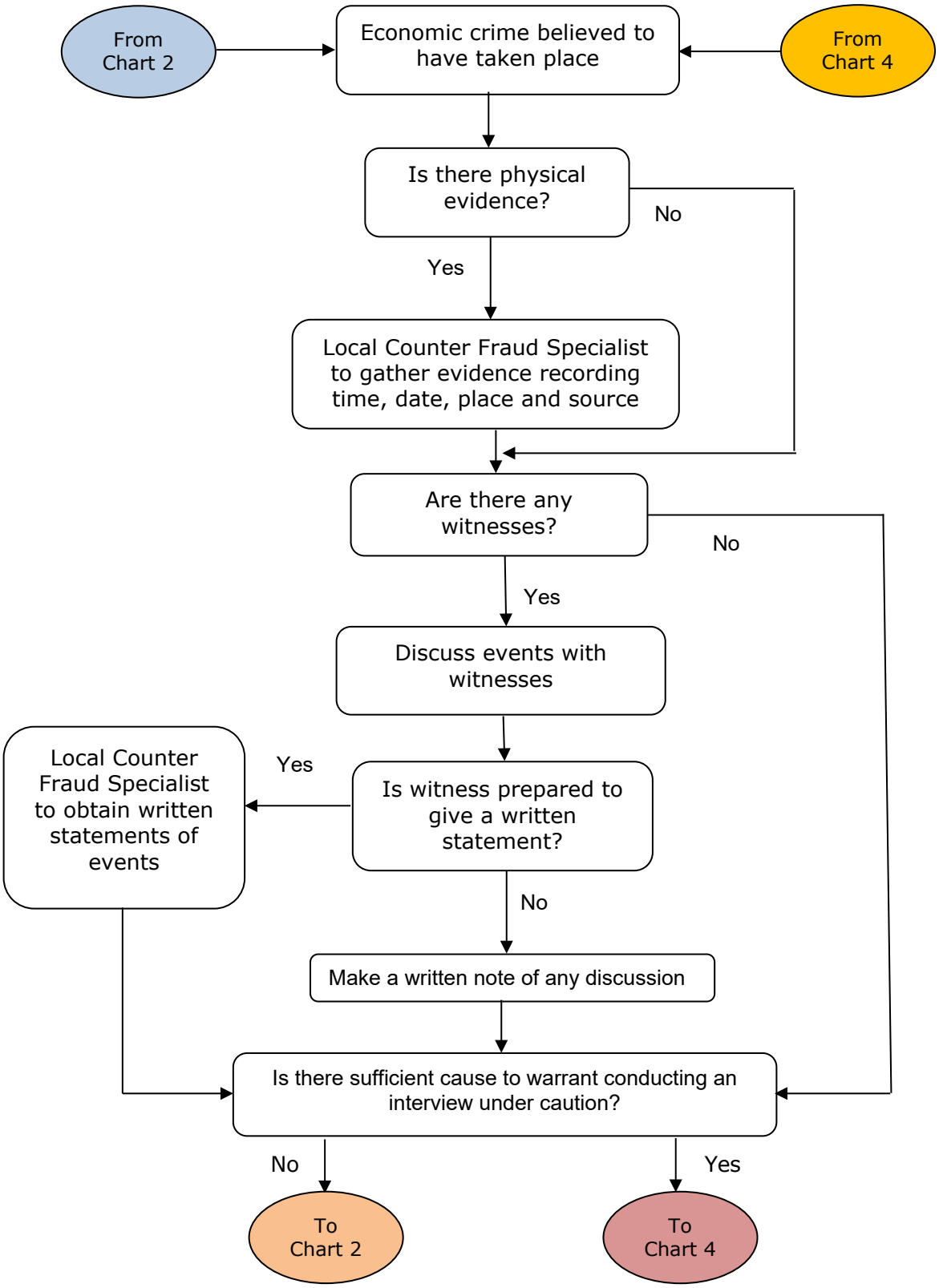
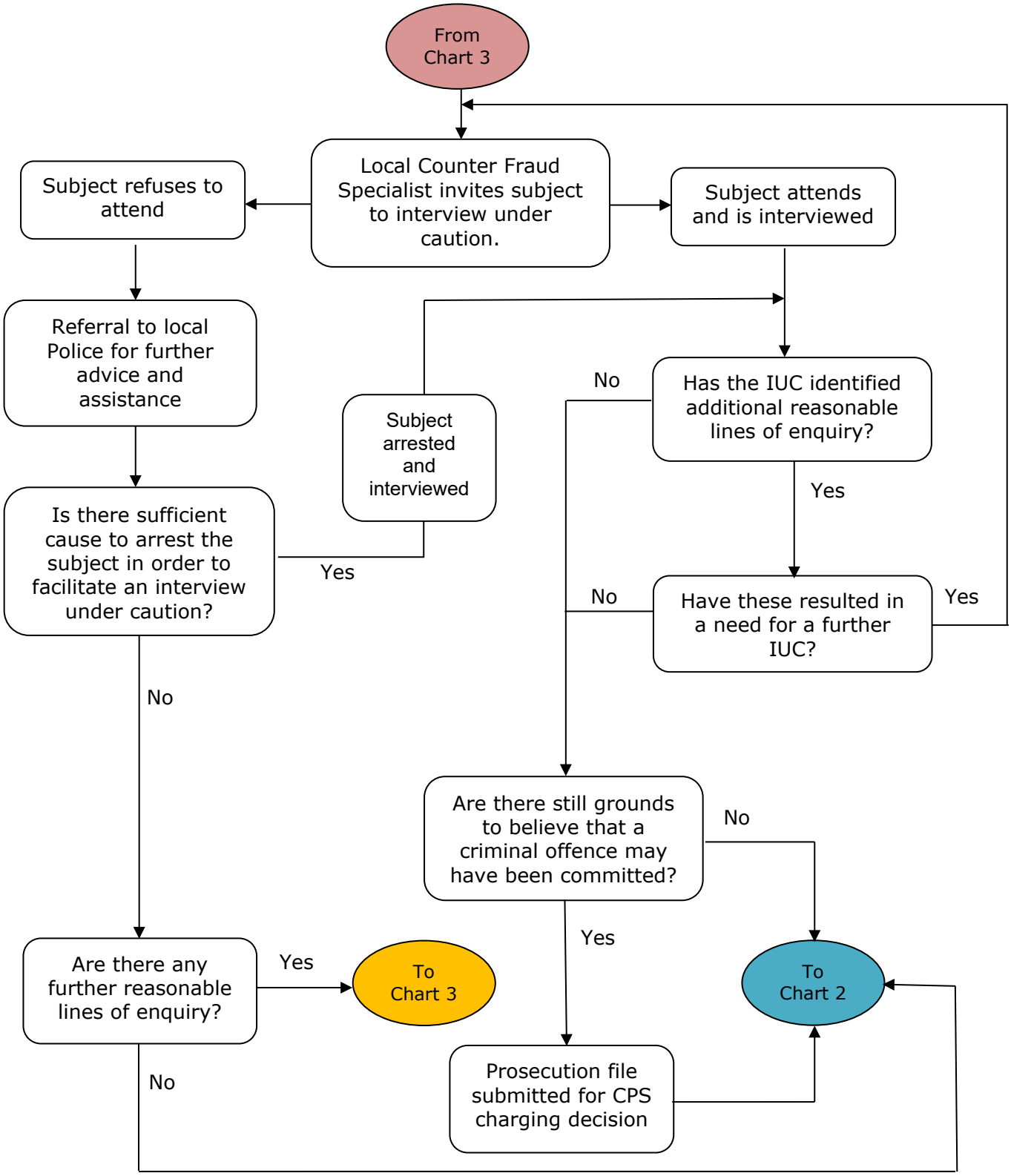


CHART 4 - Interview under Caution & Further Enquiries



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Appendix B

Examples of Fraud

Examples of areas where economic crime can and does occur within NHS Wales includes:

- Intentionally submitting false or inflated expenses and/or subsistence claims.
- Altering work records/timesheets/clock-cards to claim payment or time off for work not carried out.
- Submission of false or inflated invoices by the suppliers of goods or services.
- Working in other employment whilst claiming sick pay from the Health Board.
- Placing requisitions and/or orders for goods or services for personal use.
- Using petty cash to obtain reimbursement of items for personal use.
- Bank mandate fraud.
- Knowingly failing to disclose and return salary overpayments received.
- Using Health Board property and facilities for personal use without the knowledge or consent of the organisation.
- Undertaking private work in NHS time.
- The submission of false or misleading claims by primary care contractors.
- Inappropriately awarding work to suppliers/contractors in exchange for gifts/money.
- Providing false or misleading information on application forms, such as failing to declare previous convictions (including those that are spent).

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FRAUD **is the dishonest intent to obtain a financial gain from, or cause a loss to, a person or party through false representation, failing to disclose information, or abuse of position**

BRIBERY/CORRUPTION **is offering, giving, requesting or receiving a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.**

DO

Note your concerns

- **Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**

Retain evidence

- **Retain any evidence that may be destroyed, or make a note and advise your LCFS.**

Report your suspicion

- **Confidentiality will be respected – delays may lead to further financial loss.**

DO NOT

Confront the suspect or convey concerns to anyone other than those authorised, as listed below

- **Never attempt to question a suspect yourself; this could alert a fraudster or lead to an innocent person being unjustly accused.**

Try to investigate, or contact the police directly

- **Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must be done in line with legal requirements in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.**

Be afraid of raising your concerns

- **The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.**

DO NOTHING!

If you suspect that fraud against the NHS has taken place, you must report is immediately by contacting one of the following:

- **The LCFS (details opposite)**
- **The NHSCFA Reporting Line on 0800 028 40 60 or online at cfa.nhs.reportfraud**
- **The Director of Finance**

Your Local Counter Fraud Specialist are:

David Jones
01443 443824
david.jones100@wales.nhs.uk

Beverley Jones
01443 445955
beverley.jones262f07@wales.nhs.uk

THIS IS YOUR NHS

DON'T LET FRAUDSTERS GET AWAY WITH IT

NHS Wales

Fighting Fraud Strategy



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01 Foreword

I am pleased to introduce this Counter Fraud Strategy for NHS Wales. This Strategy will focus efforts on the fight against criminal fraud, bribery and corruption. The Welsh Government is clear that it will not tolerate economic crime against NHS Wales. These crimes are not victimless, because they steal funding that is intended to provide services to patients. Welsh Government supports action to protect these funds and to seek redress for all economic crimes committed against NHS Wales.

With a multi-dimensional approach through criminal prosecution, fraud prevention and awareness campaigns, we are determined to not only make economic crime much harder to commit, but also to increase recovery of funding stolen from NHS Wales. We will continue to build intelligence to gain a comprehensive picture of the evolving fraud risks and to develop creative, innovative and proportionate solutions to address them.

Development of a strategic, tactical and operational response across NHS Wales means that it will be better able to target weaknesses that fraudsters are exploiting. The more money that we are able to stop getting into the hands of criminals, the more resources are available for frontline services.

I am pleased to support this important work and am confident that this strategy will be a crucial step forward in fighting fraud in NHS Wales.

Finally, I would like to thank our highly motivated staff and stakeholders for their efforts in the continued fight against fraud, bribery and corruption within the NHS in Wales.

Dr Andrew Goodall CBE
Chief Executive, NHS Wales
June 2019

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02 Executive Summary

The prevalence and scale of economic crime, including all aspects of fraud, is an increasing concern for the UK. The aims of this Strategy are to prevent fraud from taking place in NHS Wales, and to increase the likelihood of detecting fraud with appropriate sanctions applied where appropriate. We will achieve this through:

- Using intelligence to understand the nature of fraud risks;
- Educating and engaging staff and stakeholders to raise awareness of the potential for fraud and the harm that it causes; and
- Pro-actively detecting and investigating frauds and securing appropriate sanctions.

Fraud against the NHS, which for the purpose of this document includes fraud, bribery, corruption and other relevant unlawful activity, affects all those who work within it and all those who rely upon it. Fraud steals valuable NHS resources, increases costs, reduces efficiency and undermines public confidence. NHS Wales and the Welsh Government are clear that fraud cannot be tolerated as it is unacceptable, and takes away vital resources intended for the provision of high quality patient care. Whilst controls to prevent fraud are in place, these must continually evolve over time to reflect learning, progress and an understanding of new potential risks and system weaknesses. As such, NHS Wales will focus its resources on prevention and detection activity, where these are likely to have the most impact.

Our approach includes the application of sanctions by means of criminal and disciplinary proceedings, in tandem with action to recover monies defrauded, via civil recovery or under the powers given by the Proceeds of Crime Act 2002. In the five years to 31 March 2019, 388 sanctions have been applied, and £2.3m of monies defrauded from NHS Wales reclaimed and returned to fund patient care.

The types of fraud that we particularly face includes:

- Procurement frauds;
- Contractors – inflated invoices/collusion in awarding of contracts;
- Dentists, GPs, Opticians, Pharmacists – claiming for treatments not provided to patients;
- Patients – falsely claiming exemption from NHS Charges;
- Staff – working while sick, timesheets and expenses, false qualifications;
- Grants to Voluntary Organisations; and
- Cyber Fraud.

The challenges that we face, in an environment where fraud risks are continually evolving, and where the level of fraud activity is believed to be increasing, are:

- There is a lack of comprehensive analysis of specific fraud risks which may result in counter fraud resources not being directed to the most appropriate areas; and
- Although each Health Board and Trust are required to appoint a Local Counter Fraud Specialist (LCFS), there is no benchmark for the level of resource that should be invested in counter fraud activity, resulting in significant variation in resourcing levels.

The scale and prevalence of economic crime, the wide variety of areas affected, and the challenges mentioned above, all point to the need for targeted and co-ordinated action to effectively tackle the problem.



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03 Strategic Objectives

Our vision is to have an NHS in Wales, which is able to protect the resources needed for front-line patient care from fraud. To do this we need to have a co-ordinated approach:

- which educates and engages with staff and stakeholders to raise awareness of the potential for fraud and the harm that it causes;
- that uses intelligence to understand the nature of fraud risks; and
- pro-actively detects, investigates frauds and secures sanctions at all levels.

The key strategic objectives for NHS Wales over the mid-term are:

Inform and Involve

- continue to improve the approach to joint working
  - ➔ ensure that Counter Fraud Services are aligned and engaged with Audit & Assurance, the Post- Payment Verification Teams, and the Auditor General's auditors.
- reinforce the clear message that fraud will not be tolerated
  - ➔ continue to raise awareness with staff and stakeholders; and
  - ➔ ensure clear guidance on how to report suspicions.

Prevent and Deter

- identify the key fraud risks to NHS Wales:
  - ➔ undertake regular risk assessments;
  - ➔ work jointly with partners to make better use of data analytics;
  - ➔ in-depth analysis of relevant information; and
  - ➔ review existing sources of assurance.
- Maximise the benefits of partnership working
  - ➔ Sharing information and learning lessons with organisations such as the Auditor General, NHS Counter Fraud Authority, Health Inspectorate Wales, the Home Office, Cabinet Office and Welsh Government.
  - ➔ Continually reviewing and improving our system controls to address identified weaknesses.

Hold to Account

- ensure a consistent and comprehensive approach to counter fraud across the whole of NHS Wales:
  - ➔ develop a benchmark for LCFS resource in each organisation in NHS Wales;
  - ➔ require all NHS organisations to achieve a green rating against the Counter Fraud Standards; and
  - ➔ invest in and develop the Counter Fraud capacity across NHS Wales and develop a talent pipeline.
- improve the capacity for financial investigation work:
  - ➔ maintain a minimum resource of two financial investigators;
  - ➔ arrange additional training to reinforce cover arrangements and succession planning.

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04 Strategic Framework

Countering fraud requires a multi-faceted approach that is both proactive and reactive.

The various bodies involved in countering fraud within NHS Wales comply with broad principles to guide their work to minimise the incidence of fraud and to deal effectively with those who commit fraud against the NHS.

The overall requirement underpinning these principles is effective strategic governance, strong leadership and a demonstrable level of commitment to tackling fraud from senior management across NHS Wales. The key principles, which are the overarching areas scored by the NHS Counter Fraud Authority in the Counter Fraud Standards, are:

Inform and Involve – raising awareness with NHS Wales staff, stakeholders and members of the public in highlighting the fraud risks, the consequence of those risks to the NHS, and the measures taken against those found to have committed fraud;

Prevent and deter – providing solutions to mitigate identified fraud risks, undertaking proactive targeted work to detect possible fraudulent activity based on effective analysis of data, and discouraging individuals who may be tempted to commit fraud against the NHS;

Hold to Account – investigate allegations of fraud thoroughly and to the highest professional standards, and where appropriate seek the full range of civil, criminal and disciplinary sanctions and seek redress where possible; and

Strategic Governance – Fraud is constantly evolving and continuous re-evaluation and improvement is needed to ensure that our approach remains effective.

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NHS Wales Strategic Framework for Counter Fraud



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05 Resources

The primary approach to counter fraud services in NHS Wales is through the following:



Health Boards, Trusts and Special Health Authority

Local Counter Fraud Specialists



All Wales

Counter Fraud Service Wales



Specialist Support

NHS Counter Fraud Authority

- Welsh Government Directions on Counter Fraud require each Health Body to nominate qualified Local Counter Fraud Specialists, recognised and accredited by the Counter Fraud Professional Accreditation Board. There are currently 20 LCFS in Wales, all directly employed by NHS bodies. LCFS are the primary point of contact for all economic crime concerns within the health body they serve. They agree work plans with their respective organisations covering a balance of proactive (fraud awareness and detection) and reactive (fraud investigation) work, closely aligned to the delivery of the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

- The Counter Fraud Services Wales (CFSW) comprises seven experienced, accredited and trained investigators. The role of CFSW is to investigate large scale and complex economic crime and provide specialist operational guidance to the LCFS network. The CFSW are authorised to utilise restricted financial investigation powers under the Proceeds of Crime Act 2002, and currently have two fully trained investigators to undertake this work.

- The NHS Counter Fraud Authority (NHSCFA) is a special health authority providing services to NHS England. In accordance with a Section 83 Government of Wales Act 2006 arrangement, the NHSCFA provides specialist operational support services to NHS Wales. These include Forensic Computing and Specialist Dental services and the Welsh Government pay directly for these services via an annual SLA.

In addition to the above, the following functions also have a direct role in countering fraud:

- **Primary Care Services (PCS)** – The Post Payment Verification (PPV) team in PCS undertake checks within General Medical Services, General Ophthalmic Services and Community Pharmacy. Similar checks on Dental Services in NHS Wales are conducted via an agreement with NHS (England) Business Services Authority. The purpose of the checks is to provide assurance to the Health Boards that claims for payment made by primary care contractors are appropriate, and that the delivery of the service is as defined in the NHS service specification and relevant legislation. There is regular liaison and an Information Sharing Protocol with the CFSW and LCFS teams, with any potential fraud concerns referred for investigation.

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- **Audit & Assurance** - all NHS bodies in Wales receive internal audit and assurance services delivered by the NWSSP Audit & Assurance Team. While they are not directly responsible for detecting fraud, their controls and assurance work can both highlight system weaknesses, and potential breaches of controls, which may indicate a higher propensity for fraud. In such circumstances, they work with the relevant LCFS to achieve a co-ordinated response. In addition, an Information Sharing Protocol between the LCFS and Audit & Assurance helps to reinforce the good relationship between the Counter Fraud and Internal Audit services;

- **Auditor General for Wales (Auditor General)** – all NHS bodies in Wales are subject to an external audit by the Auditor General. Whilst the work undertaken by the Auditor General's auditors is again not directly targeted at fraud, they too may uncover system weaknesses or actual indications of fraud. There is regular liaison between the Auditor General's auditors and CFSW to discuss possible fraud concerns;

- **National Fraud Initiative (NFI)** - The NFI was established by the Audit Commission in 1996 and matches data within and across public bodies every two years to identify anomalies that may be due to fraud. NFI is run in Wales by the Auditor General under statutory data matching powers. Since NFI started, it has found more than £35m in fraud and overpayments across the Welsh public sector and the latest biennial NFI exercise uncovered £5.4m, an increase of £1m from the previous exercise.

In addition to the specific measures highlighted above, it is incumbent on all NHS staff to be vigilant in identifying potential opportunities for, and/or actual occurrences of, fraud and to report any concerns to CFSW or the health body LCFS.



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06 Governance

The Counter Fraud Steering Group (CFSG) provides the prime governance and oversight for counter fraud arrangements in NHS Wales. The group is a subgroup of the all-Wales Directors of Finance Forum. The role of the CFSG is to provide strategic oversight and review of the counter fraud service provided to NHS Wales, and to make recommendations for change to Welsh Government and to the NHS Wales Directors of Finance Group for adoption.

The Group is chaired by the NWSSP Director of Finance and Corporate Services, with a current membership, which includes:

- Welsh Government representative
- NHS Wales Directors of Finance representative
- NHS Wales Audit Committee Chairs representative
- NWSSP Director of Audit & Assurance
- NWSSP Director of Primary Care Services
- NHS CFS Wales Operational Fraud Manager
- NHS Counter Fraud Authority representative
- NHS Wales LCFS representative
- NWSSP Head of Corporate Services
- NWSSP Legal & Risk Representative
- Auditor General representative (Observer)

Operationally, all local counter fraud services across Wales report to their Finance Directors and have their annual work plans approved and monitored by the Audit Committees in each organisation. These will typically meet four to five times a year and the respective LCFS for each organisation will attend the Committees and present their annual work plans, progress report and annual report to the appropriate meetings.

In addition, the CFS Wales Operational Fraud Manager presents updates on NHS Wales counter fraud activity, proactive work, potential risks, and accurate data on resources and sanctions via quarterly and annual reports and regularly updates the Health and Social Services Audit and Risk Committee of Welsh Government on fraud risks in NHS Wales.

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07 Quality Assurance

The quality of services is measured by compliance with the Fraud, Bribery and Corruption Standards (the standards), produced by the NHS Counter Fraud Authority, and adopted by NHS Wales. The standards are designed to ensure that counter fraud, bribery and corruption measures are implemented in accordance with the Minister for Health and Social Service directions, and the service level agreement between the Welsh Government and the NHS Counter Fraud Authority.

There are currently 23 standards, grouped under the following four key principles:

- **Inform and Involve** – assesses measures to raise fraud awareness, and to highlight the consequences of fraud;
- **Prevent and Deter** – assesses how an organisation discourages individuals from committing fraud, and ensuring that opportunities for fraud to occur are minimised;
- **Hold to Account** – assesses the arrangements to detect and investigate fraud, and how redress is sought through the appropriate application of sanctions; and
- **Strategic Governance** – assesses an organisation's strategic governance arrangements, to ensure that appropriate measures are embedded at all levels.

The quality assurance programme comprises two main processes: assurance and assessment. The assurance process primarily focuses on an annual self-review against the standards, which is undertaken by the organisation and the results submitted to the NHSCFA. The assessment process is then undertaken by the NHSCFA Quality and Compliance team.

The Self-Review Tool, supporting evidence and inspection process enables an independent assessment of the counter fraud resources and performance at the health body.

The annual assessments indicate that NHS Wales LCFS performance is generally positive, and confirm that any recommended improvements or enhancements are promptly addressed.

In addition, the work of the CFSW team is also subject to a cyclical governance assurance review, again conducted by the NHS CFA. This was last undertaken during 2017, and found that:

"In summary the CFS Wales conducts criminal investigations professionally and thoroughly. They comply with current legislation and NHS operational policies governing the conduct and management of criminal cases, including use of the FIRST case management system. The advice, guidance and support they provide to the wider counter fraud community in Wales is appreciated".

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08 Conclusion

NHS Wales and the Welsh Government is committed to sustaining and improving the health and wellbeing of the people of Wales. Maximising the use of resources is crucial to delivering on this commitment. We are therefore determined to combat NHS fraud wherever it arises and continue to adopt a co-ordinated approach to ensure that as far as possible healthcare funding is used for legitimate patient care.

To achieve this we need a shared vision and common sense of purpose i.e. of a Welsh Health Service where fraud is not allowed to flourish but which is mitigated and reduced through targeted interventions, supported by an anti-fraud culture in which all staff and stakeholders are engaged.

This strategy will help in engaging fully with all those who have a role in protecting services and resources and further raise the profile of the detrimental impact of fraud. The strategy will be supported by a detailed action plan that will be regularly monitored by the Counter Fraud Steering Group.

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02 Executive Summary

03 Strategic Objectives

04 Strategic Framework

05 Resources

06 Governance

07 Quality Assurance

08 Conclusion

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Reporting Fraud

Report NHS fraud securely and confidentially by using the NHS Counter Fraud Authority's online reporting tool or by calling our free phone line on ***0800 028 40 60***.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

GIG CYMRU NHS WALES

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.4** **28 October 2019**

AUDIT COMMITTEE REPORT

DRAFT REVIEW OF AUDIT COMMITTEE TERMS OF REFERENCE

Executive Lead: Director of Governance / Board Secretary
Author: Director of Governance / Board Secretary
Contact Details for further information: Georgina Galletly, 01443 744818 or email Georgina.Galletly2@wales.nhs.uk

Purpose of the Audit Committee Report
The purpose of this report is to seek Committee endorsement for the revised Terms of Reference for the Audit Committee prior to submission for formal approval to the Health Board in November.

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 2019-2022, 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 the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	A proposal for the shift of risk from QSR Committee to Audit Committee was agreed by IMs in August following a proposal put forward by the Chair.
Engagement – Who has been involved in this work?	
Independent Members of the Board, QSR Committee and Audit Committee.	

Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**		**NOTE**	
Recommendation	The Audit Committee is asked to: • **ENDORSE** the revised Terms of Reference for onward submission for Health Board approval.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	There are no equality and diversity implications of this report – related issues will be or have been considered within individual service change / redesign updates referenced within this report.						
Legal implications	There are no legal implications contained within this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Population Health	No direct implications of this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Quality, Safety & Patient Experience	Ensuring that the Board and its Committee(s) make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.						
Resources	No specific implications.						
Risks and Assurance	Ensuring the Board is fully sighted on key areas of its business is essential to positive assurance processes and related risk management.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	There are no direct implications on workforce in this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Freedom of information status	Open						

REVISION OF AUDIT COMMITTEE TERMS OF REFERENCE

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to seek Audit Committee endorsement for the revised Terms of Reference for the Audit Committee prior to submission to the Health Board at its meeting in November for formal approval.

2. BACKGROUND / INTRODUCTION

2.1 To address a number of observations from external agencies (Wales Audit Office (WAO)/Healthcare Inspectorate Wales (HIW)) and help manage the scrutiny and assurance requirements of the Board, it is proposed that oversight responsibility for the scrutiny of the effectiveness of risk identification, escalation and management is transferred from the Quality, Safety and Risk Committee to the Audit Committee.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 To ensure completeness, the Quality, Safety & Risk (QSR) Committee will receive revised Terms of Reference (TOR) at their meeting on 5 November 2019 outlining the changes to their responsibilities in line with this change.

3.2 Pending approval by both the current QSR and Audit Committees, both sets of revised ToRs will be submitted to the Health Board at their meeting on 28 November 2019 for formal approval and immediate implementation.

3.3 Periodically, the Welsh Government review and issue Model Standing Orders, Reservation and Delegation of Powers for health bodies to adopt and implement.

3.4 It should be noted that the section on Charitable Funds (p4) will be reviewed following the formal establishment of a Charitable Funds Committee for the Health Board in early 2020.

3.5 All proposed changes are tracked as red for ease of reference in the attached revised draft ToRs.

4. RECOMMENDATION

The Audit Committee is asked to:

- **ENDORSE** the revised Terms of Reference for the Audit Committee, for onward submission to the Health Board in November for formal approval and implementation.

Freedom of information status	Open

AUDIT COMMITTEE
TERMS OF REFERENCE

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the organisation 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".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee).

The Committee is an independent member committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. The Committee will function in accordance with the NHS Audit Committee Handbook.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

SCOPE AND DUTIES

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;

- the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation;

- the Health Board's Organisational Risk Register and the adequacy of the scrutiny of strategic risks by assigned Committees;

- the Board Assurance Framework;

- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements.

- the operational effectiveness of policies and procedures

- the effectiveness of risk identification, management, escalation and monitoring

- the policies and procedures for all work related to fraud and corruption as set out in the National Assembly for Wales Directions and as required by NHS Protect and the Counter Fraud and Security Management Service.

- proposed changes to the Standing Orders, Scheme of Delegation, Standing Financial Instructions and Financial Control Procedures.

- the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived.

The Committee will also:

- Receive and determine action in response to the declaration of Board member and other officers interests in accordance with advice received from the Director of Corporate Services & Governance / Board Secretary;

- Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers;

- Review all losses and special payments;

- Retrospectively assure any purchase / expenditure above the delegated financial limit of the Chief Executive.

Internal Audit

The Committee shall:

- consider the proposals for accessing internal audit services via a shared services arrangement (where appropriate), the audit fee and any questions of resignation and dismissal;

- review the internal audit programme, consider the major findings of internal audit investigations, ensure co-ordination between the Internal and External Auditors and ensure all management responses to recommendations are appropriate and timely;

- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organization;

- assure itself that IA complies with the requirements of the public sector internal audit standards.

- Monitor the timely implementation by management of agreed audit recommendations.

Clinical Audit

- Ensure where appropriate and in line with the Audit Committee Handbook that the CTMUHB has a Clinical Audit Programme in place and the outcomes of Clinical Audit provide internal assurance to the Board.

External Audit

The Committee shall consider the work carried out by key sources of external assurance, in particular but not limited to the Health Board external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

The Committee will:

- from time to time, consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner;

- discuss with the External Auditor, in line with the agreed audit plan, before the audit commences, the nature and scope of the audit, and ensure

coordination, as appropriate, with other External Auditors in the local health economy and with Internal Audit;

- review External Audit reports, including value for money reports and annual audit letters, together with the management response;

- Monitor the timely implementation by management of agreed audit recommendations;

- Receive a report from the Auditor General for Wales / Wales Audit Office on the results of his audit of the annual accounts before recommending adoption of those accounts to the Accountable Officer and the Health Board.

Financial Reporting

The Committee shall review the annual financial statements before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;

- major judgemental areas;

- significant adjustments resulting from the audit;

- compliance with legal requirements;

- review any material mis-statements identified during the Audit.

Charitable Funds

The Committee will:

- Ensure that the CTMUHB policies and procedures for charitable funds investments are followed and make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
    - Trustee Act 2000
    - The Charities Act 1993
    - The Charities Act 2006
    - Terms of the fund's governing documents
    - Annual Reporting to the Trustees

- Receive at least twice per year reports for ratification from the Director of Finance on investment decisions and action taken through delegated powers upon the advice of the CTMUHB's investment adviser if appropriate.

- Oversee and monitor the functions performed by the Director of Finance and procurement as defined in Standing Financial Instructions.

- Monitor the progress of any associated Charitable Appeal Funds.

- Monitor and review the CTMUHB scheme of delegation for Charitable Funds expenditure and set and reflect in Financial Control Procedures the approved delegated limits for expenditure from Charitable Funds.

AUTHORITY

The Committee is authorised by the Board to:

- investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;

- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

MEMBERSHIP

The Committee shall be appointed by the Board from amongst the Non-Officer Members of the Health Board and shall consist of not less than 4 members.

The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

The Health Board shall appoint the Chair of the Committee.

The Chair of the Health Board shall not be a member of the Committee.

The Director of Corporate Services & Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year, the Committee will meet privately with the External and Internal Auditors without any Executive Director or officer present. The opportunity to meet with Auditors privately will be available at each meeting.

The Chief Executive and Chair shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts. The Director of Finance for WHSSC and Committee Secretary will normally attend the meetings of the

Audit Committee. The Director of Specialised and Tertiary Services and the Chair of the Welsh Health Specialised Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.
The Emergency Ambulance Services Commissioner and the Chair of the Emergency Ambulance Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.

Other Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

The Health Board Local Counter Fraud Specialist will attend meetings of the Committee.

The Head of Internal Audit and the External Auditor shall have unrestricted direct access to the Chair of the Committee.

Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the CTMUHB Chair – taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

The Independent Member who is the nominated Audit Lead for WHSSC and EASC must be a member of the Audit Committee.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Corporate Services & Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of organisational development for committee members.

COMMITTEE MEETINGS

Quorum

A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, an Independent Member will be nominated to Chair the Committee.

Frequency of Meetings

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of Individuals in Attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Corporate Services & Governance / Board Secretary will ensure that all papers are distributed at least one calendar week in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports.

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the CTMUHB Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Services & Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Chair of the Audit Committee and the Director of Finance as the Executive Lead will meet with Chairs of other Board Committees as part of the Integrated Governance Group, informing the development of the Annual Governance Statement for the Health Board.

The Committee, through the Committee Chair and members, shall maximise cohesion and integration across all aspects of governance and assurance through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information, as appropriate.

The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

REVIEW

These Terms of Reference shall be adopted by the Audit Committee at its first meeting and subject to review at least on an annual basis thereafter.

For review in January 2020 – to support the establishment of the Charitable Funds Committee for the Health Board.

DRAFT

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.5** **28 October 2019**

AUDIT COMMITTEE REPORT

ADOPTION OF MODEL STANDING ORDERS

Executive Lead: Director of Governance / Board Secretary
Author: Director of Governance / Board Secretary
Contact Details for further information: Georgina Galletly, 01443 744818 or email Georgina.Galletly2@wales.nhs.uk

Purpose of the Audit Committee Report
The purpose of this report is to seek Audit Committee endorsement for the adoption of Welsh Government's Model Standing Orders for Health Boards, prior to onward submission to the Health Board at its meeting in November for formal approval.

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 2019-2022, 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 the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	Model Standing Orders have been issued by Welsh Government for adoption by all Health Bodies in Wales.
Engagement – Who has been involved in this work?	
Welsh Government WHC (2019)027 directs all health bodies to adopt the Model Standing Orders.	

Audit Committee Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	
Recommendation	The Audit Committee is asked to: • **ENDORSE** the revised Standing Orders for onward submission for Health Board approval.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	There are no equality and diversity implications of this report – related issues will be or have been considered within individual service change / redesign updates referenced within this report.						
Legal implications	There are no legal implications contained within this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Population Health	No direct implications of this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Quality, Safety & Patient Experience	Ensuring that the Board and its Committee(s) make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.						
Resources	No specific implications.						
Risks and Assurance	Ensuring the Board is fully sighted on key areas of its business is essential to positive assurance processes and related risk management.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	There are no direct implications on workforce in this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Freedom of information status	Open						

ADOPTION OF MODEL STANDING ORDERS

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to seek Audit Committee endorsement for the adoption of Welsh Government's Model Standing Orders for Health Boards, prior to onward submission to the Health Board at its meeting in November for formal approval.

2. BACKGROUND / INTRODUCTION

2.1 Periodically, the Welsh Government review and issue Model Standing Orders (SOs), Reservation and Delegation of Powers for health bodies to adopt and implement.

2.2 It is necessary to ensure that Local Health Board (LHB), Trust, Welsh Health Specialised Services (WHSCC) and Emergency Ambulance Services Committee (EASC) Model Standing Orders are kept up to date and take account of any developments. Whilst individual organisations are responsible for review of their respective documents they are informed by Model SOs issued using the Ministers power of direction in accordance with Sections 12(3) and 19(1) of the National Health Service (Wales) Act 2006. In September 2019 the Welsh Government issued revised Model Standing Orders for Local Health Boards (LHBs), Trusts and the Welsh Health Specialised Services Committee (WHSSC). Model SOs for the Emergency Ambulance Services Committee (EASC) were issued for the first time.

2.3 Following receipt of the Model SOs the Health Board has reviewed the organisations Standing Orders. WHSSC and EASC have also considered the Standing Orders for the respective Committees and the Model Standing Orders are incorporated as Schedules 4.1 and 4.2 of the LHB SOs.

2.4 It is worth noting that within the new SOs for EASC, there is a role for a dedicated Committee Secretariat. CTMuHB is working with EASC to action this as a priority.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Model Standing Orders (SO's) and Reservation and Delegation of Powers for Local Health Boards, Trusts and the Welsh Health Specialised Services Committee (WHSSC) were issued in 2009 in accordance with the Welsh Ministers powers of Direction. Revised model documents were subsequently issued in 2012 and 2014.

3.2 Model SO's have not previously been issued for the Emergency Ambulance Services Committee (EASC) and the Committee has been working to SO's adapted from the WHSSC SO's. The SOs for WHSSC and EASC form a schedule of the LHB SOs.

3.3 NHS organisations in Wales are required to review their SOs annually. Some organisations have held off undertaking a review in expectation of issue of updated Model SOs. This has been highlighted within a number of Structured Assessments undertaken by the Wales Audit Office.

3.4 There have been a number of changes to legislation which require a change in the governance arrangements within NHS organisations such as the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. It is necessary for the Model SOs to reflect these changes.

3.5 In November 2018 the Minister issued a direction to LHBs regarding changes to the voting arrangements for WHSSC, EASC and the NHS Wales Shared Services Partnership Committee (SSPC.) This latest review incorporates these changes. (Note: Model SOs are not issued for the SSPC as these are a Schedule within the Velindre SOs).

3.6 Welsh Government also issues Model Standing Financial Instructions (SFIs). The SFIs are incorporated within Schedule 2 of the SOs and will have effect as if incorporated directly into the SOs. The timing of their review traditionally has coincided with the review of the Model SOs. On this occasion the Model SFIs are being reviewed on a different timeline. A Task and Finish Group has been established to take this work forward with the involvement of a representative of the Board Secretaries and Director of Finance Networks.

4. RECOMMENDATION

The Audit Committee is asked to:

- **ENDORSE** the adoption of the Model Standing Orders as detailed in the attached revised SOs for the Health Board, for onward submission to the Health Board in November for formal approval and implementation.

Freedom of information status	Open

~~Model~~ Standing Orders

Reservation and Delegation of Powers

For Cwm Taf Morgannwg University ~~Local~~ Health Board

Adopted from the Model Standing Orders issued by Welsh Government in September 2019

Date approved:	1 April 2019
Approved by:	Health Board
Review date:	March 2020
Version:	Ten

Responsible Director: Director of Corporate Governance/Board Secretary

Distribution: Board Members
All staff

FOI Status: Open

~~s~~

Foreword

These Standing Orders are adopted from the 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 (~~LHB~~LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs ~~LHB~~LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers. These SOs 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~~LHB.

These documents form the basis upon which the ~~LHB~~LHB's governance and accountability framework is developed and, together with the adoption of the ~~LHB~~LHB's Values and Standards of Behaviour framework ~~**[LHB to insert title of relevant policy]**~~, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All ~~LHB~~LHB 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 ~~LHB~~LHB.

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 ~~[insert name]~~Cwm Taf Morgannwg University ~~Local~~ Health Board (the UL~~L~~HB) 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)**, "the Establishment Order". "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.

~~FOR POWYS INSERT~~

~~Powys Teaching Local Health Board (the LHB) is a statutory body that was established on 1 April 2003 and became operational on the 1 June 2003 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2003 (S.I. 2003/148)**, "the Establishment Order".~~

ii) The principal place of business of the UL~~L~~HB is ~~–~~ Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN.

~~ii) [insert address]~~

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

iv) ~~LHB~~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** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** 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 ~~LHB~~LHBs are governed and their functions.

~~v)~~ Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations**

v) **2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of ~~LHB~~LHBs, which includes a requirement for ~~LHB~~LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension.

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

~~vii)~~ **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven ~~LHB~~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 ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the

vii) NHS (Wales) Act 2006, the Welsh Ministers have made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

~~viii)~~ **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven ~~LHB~~LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those

functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales)**

viii) **Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance which ~~LHB~~LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers ~~LHB~~LHBs must be clear about the statutory basis for exercising such powers.

x) As a statutory body, the ~~LHB~~LHB has specified powers to contract in its own name and to act as a corporate trustee. The ~~LHB~~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.

~~xi)~~ The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable ~~LHB~~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 Area Plan developed in accordance with the **Social Services and Wellbeing (Wales) Act 2014 (2014).**

~~xii)~~xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to cooperate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

~~xiii)~~xii) 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.

~~xiv)~~xiii) Further duties and powers placed on health boards in relation to cooperation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and ~~LHB~~LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for ~~LHB~~LHBs and local authorities to pool funds for the purpose of providing specified services**.**

Guidance on the provisions of Part 9 can be found at https://gov.wales/docs/dhss/publications/151218part9en.pdf

~~xv)~~xiv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on ~~LHB~~LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

~~xvi)~~ The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh

xv) Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

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

NHS framework

xviii) In addition to the statutory requirements set out above, ~~LHB~~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 are expected at all levels of the service, locally and nationally.

xix) Adoption of the principles will better equip ~~LHB~~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.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link:
http://www.wales.nhs.uk/governance-emanual/values-and-standards-ofbehaviour-framew

xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

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.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of ~~LHB~~LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the ~~LHB~~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. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxiv) ~~LHB~~LHBs will from time to time agree and approve policy statements which apply to the ~~LHB~~LHB's Board members and/or all or specific groups of staff employed by CTMuHB~~[**insert name**] 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~~UHB's SOs and SFIs. Details of the ~~LHB~~UHB's key policy statements are also included in Schedule 2.

xxv) ~~LHB~~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 xxxiii below).

xxvi) For the purposes of these SOs, the members of the ~~LHB~~UHB 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~~LHB (together with SFIs and the Values and Standards of Behaviour Framework ~~**[LHB to insert title of relevant policy]**~~), will, as far as they are applicable, also apply to meetings of any formal Committees established by the ~~LHB~~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 and further details on joint-Committees may be found in Schedule* 4.

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 [**or insert name of Committee established to consider audit matters**]~~ Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and ~~LHB~~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.

xxix) **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

xxx) Although these SOs are subject to regular, annual review by the ~~LHB~~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 [**or insert name of Committee established to consider audit matters**] and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the ~~LHB~~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).

~~xxxii)~~ 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.

xxxii)

The role of the Board Secretary

xxxiii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within ~~LHB~~LHBs, and is a key source of advice and support to the ~~LHB~~LHB Chair and other Board members.

Independent of the Board, the Board Secretary acts as the guardian of good governance within the ~~LHB~~LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of ~~LHB~~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~~LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

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 in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxiv) Further details on the role of the Board Secretary within CTMuHB, ~~[**insert name**] LHB,~~ including details on how to contact them, are available on the Cwm Taf Morgannwg uHB website. ~~at [**insert signpost to relevant LHB documentation**].~~

~~xxxiv)~~

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The ~~LHB~~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.

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

~~**FOR POWYS INSERT**~~

~~The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2003 (S.I. 2003/148 (W.18),** 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.~~

1.0.3 To fulfil this role, the ~~LHB~~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~~LHB shall be no more than 20 members comprising the Chair, Vice Chair, non-officer members (~~-~~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 members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the ~~LHB~~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 [to be 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 [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the ~~LHB~~LHB area; a current member or employee of a Third Sector organisation within the ~~LHB~~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 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.6 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

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

1.1.7 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'

1.1.8 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~~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 hold office as a member or associate member for the same Board for 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. An Associate member may be re-appointed if necessary or expedient for the performance of the ~~LHB~~LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

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

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

Role

1.4.1 The principal role of the ~~LHB~~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~~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 ~~LHB~~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".

1.4.5 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.

1.4.6 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~~LHB within the communities it serves.

1.4.7 **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.

1.4.8 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.

1.4.9 **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.

1.4.10 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~~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~~LHB's area.

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

1.4.12 **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~~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~~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~~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 ~~T~~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) ~~i)~~ Schedule of matters reserved to the Board;
ii) ~~ii)~~ Scheme of delegation to committees and others; and
iii) ~~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 4, the ~~LHB~~LHB retains full responsibility for any ~~y~~ functions delegated to others to carry out on its behalf.

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.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) 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~~UHB (or of another ~~LHB~~LHB or Trust); or
ii) By another ~~LHB~~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 may 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 may 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 amendments 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~~LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the ~~LHB~~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 ~~LHB~~LHBs or NHS Trusts or the local authorities operating within the ~~LHB~~LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the ~~LHB~~LHB's Board members or Board members of other health service bodies or of persons who are not ~~LHB~~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.

3.2.2 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.

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

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

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 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~~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.

3.2.5 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.

3.3 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 subCommittee unless authorised to do so by the Board.

3.4 Committees established by the ~~LHB~~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.

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.

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~~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~~LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the ~~LHB~~LHB.

3.4.6 Executive Directors or other ~~LHB~~LHB officers shall not 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~~LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

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

3.6 Confidentiality

3.6.1 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.

3.7 Reporting activity to the Board

3.7.1 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. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 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 has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("**the Shared Services Regulations")** require the Velindre NHS 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 Committee in order to ensure that all ~~LHB~~LHBs and Trusts in Wales have a member on the Shared Services 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.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Cooperation Agreement and a Hosting Agreement between all ~~LHB~~LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services 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.

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

5. ADVISORY GROUPS

5.0.1 The ~~LHB~~LHB has a statutory duty to take account of representations made by persons and organisations 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~~LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The ~~LHB~~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.*

5.0.3 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.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements 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~~LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and ▪ Reporting and assurance arrangements.

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

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

5.2 Support to the Advisory Groups

5.2.1 The ~~LHB~~LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the ~~LHB~~LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

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

5.3 Confidentiality

5.3.1 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.

5.4 Advice and feedback

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

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

5.5 Reporting activity

5.5.1 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.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks 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.

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

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

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

- Early engagement and involvement in the determination of the ~~LHB~~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~~LHB's operations on the communities it serves.

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

5.6.3 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~~LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the ~~LHB~~LHBs area.

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

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

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

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

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

5.7.4 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.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, coordinated stakeholder perspective from across the local communities served by the ~~LHB~~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., Regional Partnership Boards.

5.9 Working with Community Health Councils

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

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

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

5.10.1 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.

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

5.11 Terms of reference and operating arrangements

5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

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

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

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

5.12.4 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.

5.13 Rights of Access to the ~~LHB~~LHB Board for Professional Groups

5.13.1 The ~~LHB~~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.

5.13.2 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 7.5.7.

5.14 Relationship with the National Professional Advisory Group

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

Refer to Schedule 5.2 for detailed Terms of Reference and Operating

Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the ~~LHB~~LHB, as employer, and trade unions/professional bodies representing ~~LHB~~LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the ~~LHB~~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~~LHB's workforce.

5.15.2 It is the forum where the ~~LHB~~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.

5.16 Relationship with the Board and others

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

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

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

5.16.4 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.

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

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The ~~LHB~~LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 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~~LHB through:

- The ~~LHB~~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 Regional Partnership and Public Service Boards – of Board members and ~~LHB~~LHB officers with delegated authority to represent the ~~LHB~~LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the ~~LHB~~LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnershipworking---implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 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.

6.1 Community Health Councils (CHCs)

6.1.1 The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) (as amended) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289) place a range of duties on ~~LHB~~LHBs in relation to the engagement and involvement of CHCs in its operations.

6.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the ~~LHB~~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~~LHB's area on any proposals for substantial development of the services it is responsible for.

6.1.3 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

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

6.1.5 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.

6.1.6 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.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The ~~LHB~~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~~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 (where requested or required) and in electronic formats;
- Requesting that attendees notify the ~~LHB~~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., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

7.1.2 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~~LHB, including any views expressed formally to the ~~LHB~~LHB, e.g., through the SRG or CHCs.

7.2 Annual Plan of Board Business

7.2.1 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.

7.2.2 The plan shall set out the arrangements in place to enable the ~~LHB~~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.

7.2.3 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.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website. .

Annual General Meeting (AGM)

7.2.5 The ~~LHB~~LHB must hold an AGM in public no later than the 31 July each year. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) at the ~~LHB~~LHBs principal sites and on the ~~LHB~~LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the ~~LHB~~LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 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 organisation's annual quality statement.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 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.

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

7.4 Preparing for Meetings

Setting the agenda

7.4.1 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~~LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 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

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days 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.

7.4.4 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. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments 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 assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 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.

7.4.6 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

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days 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~~LHB's principal sites; On the ~~LHB~~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~~LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the ~~LHB~~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.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The ~~LHB~~LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as ~~LHB~~LHB officers or representatives from organisations who have an interest in ~~LHB~~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.

7.5.2 The Board and its committees 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).*

7.5.3 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.

7.5.4 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.

7.5.5 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.

7.5.6 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.

Addressing the Board, its Committees and Advisory Groups

7.5.7 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~~LHB, (whether directly or through the activities of bodies such as CHCs and the ~~LHB~~LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the ~~LHB~~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.

7.5.9 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

7.5.10 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.

7.5.11 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.

7.5.12 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

7.5.13 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).

7.5.14 **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 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.

7.5.15 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.

7.5.16 **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.

7.5.17 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.

7.5.18 **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.

7.5.19 **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.

7.5.20 **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.

7.5.21 **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.

7.5.22 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

7.5.23 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.

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

7.5.25 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.

7.5.26 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.

7.6 Record of Proceedings

7.6.1 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.

7.6.2 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~~LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the ~~LHB~~LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 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~~LHB officials must respect the confidentiality of all matters considered by the ~~LHB~~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 **[~~LHB~~LHB to insert title of relevant policy],** or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the ~~LHB~~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~~LHB, including Board members, ~~LHB~~LHB officers and others, as appropriate. The framework adopted by the Board **[~~LHB~~LHB to insert title of relevant policy]** will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***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 **[~~LHB~~LHB to insert title of relevant policy],** and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their

appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 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.

8.1.3 ***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.

8.1.4 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.

8.1.5 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~~LHB are made aware of, and have access to view the ~~LHB~~LHB's Register of Interests. This may include publication on the ~~LHB~~LHB's website.

8.1.6 ***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~~LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 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~~LHB and the NHS in Wales.

8.2.2 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.

8.2.3 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.

8.2.4 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.

8.2.5 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.

8.2.6 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.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] 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.

8.2.8 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.

8.2.9 ***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~~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.

8.3 Dealing with officers' interests

8.3.1 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~~LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 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.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

[1] 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.
[2] The term gift refers also to any reward or benefit.

8.5.1 The Values and Standards of Behaviour Framework **[~~LHB~~LHB to insert title of relevant policy]** approved by the Board prohibits Board members and ~~LHB~~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.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or ~~LHB~~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~~LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 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:

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- **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~~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, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the ~~LHB~~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.

8.5.4 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.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** [~~LHB~~LHB to insert title of relevant policy] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to ~~LHB~~LHB officers working within their Directorates.

8.7.2 Every Board member and ~~LHB~~LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, 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, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **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[3]' hospitality need not be included in the Register.

8.7.4 Board members and ~~LHB~~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~~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.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the ~~LHB~~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 ~~LHB~~LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the ~~LHB~~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 has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

[3] 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.

9.0.2 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.

9.1. Register of Sealing

9.1.1 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.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the ~~LHB~~LHB, it shall 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.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the ~~LHB~~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.

9.3 Custody of Seal

9.3.1 The Common Seal of the ~~LHB~~LHB shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF ~~LHB~~LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of ~~LHB~~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.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership 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 Director of Shared Services. The 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~~LHB.

10.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the ~~LHB~~LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 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.

10.1.2 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.

10.2 Reviewing the performance of the Board, its Committees and

Advisory Groups

10.2.2 The Board shall introduce a process of regular and rigorous selfassessment 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.

10.2.3 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks 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.

10.2.4 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.

10.3 External Assurance

10.3.1 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~~LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 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.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the ~~LHB~~LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

10.3.4 The ~~LHB~~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.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 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.

11.0.2 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.

11.0.3 The Board shall also facilitate effective scrutiny of the ~~LHB~~LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the ~~LHB~~LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 *[The Board Secretary shall arrange for an appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.]*

12.0.2 These SOs shall be reviewed annually by the Audit Committee ~~[or equivalent]~~, 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 appropriate impact assessments.

Schedule 1

~~MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS~~

~~This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders~~

~~MODEL~~ SCHEME OF RESERVATION AND DELEGATION OF POWERS

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 ~~LHB~~LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

i) A Committee, e.g., Quality and Safety 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 Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other ~~LHB~~LHBs established to take forward matters relating to specialist services; and

iv) Officers of the ~~LHB~~LHB (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 ~~LHB~~LHB.

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; and ▪ Scheme of delegation to officers.

all of which form part of the ~~LHB~~LHB's SOs.

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 SOs or SFIs***

- ***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; and
- 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 Board Secretary

The 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 ~~LHB~~LHB 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[4] 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; and
- Exercising any powers delegated to them in a manner that accords with the ~~LHB~~LHB's values and standards of behaviour.

[4] ~~LHB~~LHB to insert title for the committee that carries out these functions.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[~~LHB~~LHB to insert details]** 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 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 ~~LHB~~LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the ~~LHB~~LHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[5]

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 SOs[6]
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: **[~~LHB~~LHB to insert details]**
3	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 ~~LHB~~LHB, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges

[5] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements.

[6] Except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC).

4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the ~~LHB~~LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the ~~LHB~~LHB's Values and Standards of Behaviour framework ~~**[LHB to insert title of relevant policy]**~~
6	FULL	OPERATING ARRANGEMENTS	Approve the ~~LHB~~LHB's framework for performance management, risk and assurance
7	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 ~~LHB~~LHB's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with SOs

10	FULL	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the ~~LHB~~LHB's responsibility as a bailee for patients' property
11	FULL	OPERATING ARRANGEMENTS	Approve policies for dealing with complaints and incidents
12	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with SFIs
13	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
14	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the ~~LHB~~LHB
15	FULL	OPERATING ARRANGEMENTS	Authorise use of the ~~LHB~~LHB's official seal
16	FULL	ORGANISATION STRUCTURE & STAFFING	Approve appointment and manage appraisal, discipline and dismissal of the Chief Executive
17	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the Executive Directors and any other Board level appointments, e.g., the Board Secretary
18	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
19	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the ~~LHB~~LHB's top level organisation structure and corporate policies

20	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss ~~LHB~~LHB Committees, including any joint-Committees directly accountable to the Board
21	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
22	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
23	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all Committees, jointCommittees and groups established by the Board
24	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the ~~LHB~~LHB's responsibilities as a corporate trustee for funds held on trust
25	FULL	STRATEGY & PLANNING	Determine the ~~LHB~~LHB's strategic aims, objectives and priorities
26	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
27	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB's Risk Management Strategy and plans
28	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB's citizen engagement and involvement strategy, including communication
29	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB's partnership and stakeholder engagement and involvement strategies

30	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB'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)
31	FULL	STRATEGY & PLANNING	Approve the ~~LHB~~LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
32	FULL	STRATEGY & PLANNING	Approve new contracts for the ~~LHB~~LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the ~~LHB~~LHB's population Services
33	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
34	FULL	PERFORMANCE & ASSURANCE	Approve the ~~LHB~~LHB's audit and assurance arrangements
35	FULL	PERFORMANCE & ASSURANCE	Receive reports from the ~~LHB~~LHB's Executive on progress and performance in the delivery of the ~~LHB~~LHB's strategic aims, objectives and priorities and approve action required, including improvement plans
36	FULL	PERFORMANCE & ASSURANCE	Receive reports from the ~~LHB~~LHB's Committees, groups and other internal sources on the ~~LHB~~LHB's performance and approve action required, including improvement plans
37	FULL	PERFORMANCE & ASSURANCE	Receive reports on the ~~LHB~~LHB's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc) that raise issue or concerns impacting on the ~~LHB~~LHB'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)

38	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the ~~LHB~~LHB's Chief Internal Auditor and approve action required, including improvement plans
39	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
40	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the ~~LHB~~LHB's performance against *Doing Well, Doing Better: Standards for Health Services in* Wales (formally the Healthcare Standards) and approve action required, including improvement plans
41	FULL	REPORTING	Approve the ~~LHB~~LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Assembly Government
42	FULL	REPORTING	Receive, approve and ensure the publication of ~~LHB~~LHB reports, including its Annual Report and annual financial accounts

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		[individual ~~LHB~~LHB to insert details, in accordance with statutory and Assembly Government requirements
	VICE CHAIR		[individual ~~LHB~~LHB to insert details, in accordance with statutory and Assembly Government requirements
	CHAMPION/ NOMINATED LEAD		[individual ~~LHB~~LHB to insert details, in accordance with statutory and Assembly Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[5]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

[5] As defined in Standing Orders

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including [individual ~~LHB~~LHBs to insert details]

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- **[~~LHB~~LHB to insert details]**

- **[~~LHB~~LHB to insert details]**

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the ~~LHB~~LHB's Scheme of Delegation to Committees.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The ~~LHB~~LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and

the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the ~~LHB~~LHB's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[~~LHB~~LHB to determine]	**[~~LHB~~LHB to determine]**

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

~~LHB~~LHB framework

The ~~LHB~~LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents [~~LHB~~LHB to insert details]***

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:

[~~LHB~~LHB to insert details]

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 www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of ~~LHB~~LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

[Local Health Board SFIs to be inserted]

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

[~~LHB~~LHB to insert details, including detailed Terms of Reference and Operating Arrangements for each Committee]

Schedule

4

JOINT COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

[~~LHB~~LHB to insert details, including detailed terms of reference and operating arrangements for each Committee]

Schedule 4.1 – Welsh Health Services Specialised Services Committee Schedule 4.2 – Emergency Ambulance Services Committee

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

[~~LHB~~LHB to insert details, including detailed terms of reference and operating arrangements for each Advisory Group. These must include and take account of the information detailed below in the model SO's]

Schedule 5.1 – Stakeholder Reference Group
Schedule 5.2 – Health Professionals Forum
Schedule 5.3 – Local Partnership Forum

Schedule 5.1

Stakeholder Reference Group

Schedule

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

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

- Early engagement and involvement in the determination of the ~~LHB~~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~~LHB's operations on the communities it serves.

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

1.1.3 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~~LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the ~~LHB~~LHBs area.

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

1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

1.2.1 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.

1.2.2 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.

1.2.3 Membership must be drawn from within the area served by ~~LHB~~LHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the ~~LHB~~LHB. Where the Board determines it appropriate, the ~~LHB~~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.

1.2.4 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~~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 socioeconomic status. Where appropriate, the ~~LHB~~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~~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.

1.2.5 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.

1.3 Member Responsibilities and Accountability:

The Chair

1.3.1 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~~LHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the ~~LHB~~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.

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

The Vice Chair

1.3.4 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~~LHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the ~~LHB~~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

1.3.6 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.

1.3.7 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.

1.3.8 SRG members are accountable, through the SRG Chair to the ~~LHB~~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.

1.4 Appointment and terms of office

1.4.1 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.

1.4.2 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;

1.4.3 The Board Secretary, on behalf of the Chair of the ~~LHB~~LHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 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.

1.4.5 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~~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.

1.4.6 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.

1.4.7 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~~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~~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.

1.4.8 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.

1.4.9 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.

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

1.5 Resignation, suspension and removal of members

1.5.1 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.

1.5.2 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.

1.5.3 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.

1.5.4 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.

1.5.5 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.

1.6 Relationship with the Board

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

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

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

1.6.4 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.

1.7 Relationship between the SRG and others

1.7.1 The Board must ensure that the SRG's advice represents a balanced, coordinated stakeholder perspective from across the local communities served by the ~~LHB~~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., Regional Partnership Boards.

1.8 Working with Community Health Councils

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

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

Schedule 5.2

Health Professionals' Forum

Terms of Reference and Operating Arrangements

THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

1.1 Role

1.1.1 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.

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

1.2 Terms of reference and operating arrangements

1.2.1 The Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

1.3 Membership

1.3.1 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 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

1.3.2 Where the Board determines it appropriate, the ~~LHB~~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.

1.4 Member Responsibilities and Accountability:

The Chair

1.4.1 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~~LHB's Board, and in particular its Chair, Chief Executive and clinical Directors.

1.4.2 The Chair shall work in close harmony with the Chairs of the ~~LHB~~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.

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

The Vice Chair

1.4.4 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~~LHB Board.

1.4.5 The Vice Chair is accountable through the HPF Chair to the ~~LHB~~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

1.4.6 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.

1.4.7 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.

1.4.8 Forum members are accountable through the HPF Chair to the ~~LHB~~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.

1.5 Appointment and terms of office

1.5.1 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.

1.5.2 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.

1.5.3 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.

1.5.4 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~~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.

1.5.5 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.

1.5.6 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.

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

1.6 Resignation, suspension and removal of members

1.6.1 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.

1.6.2 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.

1.6.3 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.

1.6.4 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.

1.6.5 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.

1.7 Relationship with the Board

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

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

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

1.7.4 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.

1.8 Rights of Access to the ~~LHB~~LHB Board for Professional Groups

1.8.1 The ~~LHB~~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.

1.8.2 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.

1.9 Relationship with the National Professional Advisory Group

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

Schedule 5.3

Local Partnership Forum Advisory Group Terms of Reference and Operating Arrangements

1.1 Role and Purpose

1.1.1 The ~~LHB~~LHB Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services

for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

1.1.2 At the earliest opportunity, the Board will engage with staff organisations in the key discussions at the ~~LHB~~LHB Board, LPF and Locality/Divisional level.

1.1.3 All members are full and equal members of the forum and collectively share responsibility for the decisions made.

1.1.4 The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

1.1.5 The purpose of the LPF will be to:

- Establish a regular and formal dialogue between the Board's Executive and staff organisations on matters relating to workforce and health service issues.
- Enable employers and staff organisations to put forward issues affecting the workforce.
- Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.
- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.
- Appraise and discuss in partnership the Board services and activity and its implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Board and senior management.

- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Board including matters of service re-profiling.

- Negotiate on matters subject to local determination.

- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties

- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

1.1.6 In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the ~~LHB~~LHB LPF.

1.2 General Principles

1.2.1 The ~~LHB~~LHB and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

1.2.2 The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency
- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All members must:

- be prepared to engage with and contribute fully 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.

1.2.3 A Code of Conduct is attached as Appendix 2.

1.3 Membership

1.3.1 All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the ~~LHB~~LHB recognises for collective bargaining. The Trade Union member of the ~~LHB~~LHB Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

1.3.2 Management will normally consist of the following members of management representatives:

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

1.3.3 Other Executive Directors and others may also be members or may be coopted dependent upon the agenda.

Staff Representatives

1.3.4 The Board recognises those staff organisations listed in Appendix 3 for the representation of members who are employed by the organisation.

1.3.5 Staff representatives must be employed by the organisation and accredited by their respective organisations for the purposes of bargaining. If a representative ceases to be employed by the Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF. Full

time officers of the staff organisations may attend meetings subject to prior notification and agreement.

1.3.6 Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

1.4 Quorum

1.4.1 Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.

1.4.2 If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.

1.4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the member and bring the response to the next meeting for further consideration and possible removal.

1.5 Officers

1.5.1 The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

1.6 Chairs

1.6.1 The Management and Staff Organisation Chair will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Board's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.7 Joint Secretaries

1.7.1 Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

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

1.8 Sub Committees

1.8.1 When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

1.9 Management of Meetings

1.9.1 Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

1.9.2 The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Board wide strategic issues and issues that have ~~LHB~~LHB/Trust wide implications shall be referred to the Welsh Partnership Forum via the ~~LHB~~LHB Board.

1.9.3 The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

1.9.4 The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Schedule 4.1

MODEL STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

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. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee) proceedings and business. These WHSSC Standing Orders (WHSSC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated **[insert date]** made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated **[insert date]** between the Joint Committee and Cwm Taf Morgannwg University LHB (the host LHB), form the basis upon which the Joint

Committee governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. 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 Welsh Health Specialised Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Welsh Health Specialised Services Committee (Wales) Directions 2009** (the WHSSC Directions). The functions and services of the Joint Committee are listed in Annex 1 of the WHSSC Directions and are subject to variations to those functions agreed from time to time by the Joint Committee**.** Annex 1 was amended by the **Welsh Health Specialised Services Committee (Wales) (Amendment) Directions 2014** following the establishment of the Emergency Services Ambulance Committee. The Joint Committee is hosted by the host LHB on behalf of each of the seven LHBs.

ii) The principal place of business of the WHSSC is – [**insert address**]

iii) All business shall be conducted in the name of the Welsh Health Specialised Services Committee on behalf of LHBs.

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** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) 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 LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The WHSSC Directions 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 will establish the joint committee for the purpose of jointly exercising those functions.

viii) Under powers 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** (the WHSSC Regulations) which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Host LHB shall issue an indemnity to the Chair, on behalf of the LHBs

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it 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.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and 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.

xiv) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it

does.

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

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

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These WHSSC SOs and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others;
- The WHSSC SFIs;
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) Annex 2 to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with the WHSSC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the WHSST and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these WHSSC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in Annex 2 of these SOs.

Applying WHSSC Standing Orders

xx) The WHSSC SOs (together with the WHSSC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups. The WHSSC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on joint sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these WHSSC SOs, respectively.

xxi) Full details of any non compliance with these WHSSC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee **[or insert name of committee established to consider audit matters]** to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with WHSSC SOs is a disciplinary matter.**

Variation and amendment of WHSSC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the WHSSC SOs, the Chair of the Joint Committee 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 should take appropriate advice from the Committee Secretary.

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

Relationship with LHB Standing Orders

xxv) The WHSSC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

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

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups;
- Ensuring that Joint Committee 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 Joint Committee 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 Joint Committee's compliance with the law, WHSSC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committees operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will

include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the Management Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee

1.2.1 The membership of the Joint Committee shall be 15 voting members and three associate members, comprising the *Chair* (appointed by the Minister for Health and Social Services) and the *Vice Chair* (appointed by the Joint Committee from existing non-officer members of the seven LHBs), together with the following:

Non Officer Members [known as Independent Members]

1.2.2 A total of 2, appointed by the Joint Committee from existing non-officer members of the seven LHBs.

Chief Executives

1.2.3 A total of 7, drawn from each Local Health Board in Wales.

Officer Members [known as WHSST Directors]

1.2.4 A total of 4, appointed by the Joint Committee, consisting of a Director of Specialised and Tertiary Services; a Medical Director of Specialised and Tertiary Services; a Finance Director of Specialised and Tertiary Services, and a Nurse Director of Specialised and Tertiary Services. These officer members may have other responsibilities as determined by the Joint Committee and set out in the scheme of delegation to officers. These officer members comprise the Management Team.

1.2.5 Where a post of WHSST Director 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 Joint Committee 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.

Associate Members

1.2.6 The following Associate Members will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust
- Chief Executive of the Welsh Ambulance Services NHS Trust
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.7 The Joint Committee Chair may invite other members of the WHSST or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

Use of the term 'Independent Members'

1.2.8 For the purposes of these WHSSC SOs, use of the term 'Independent Members' refers to the following voting members of the Joint Committee:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 Independent Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.3 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.4 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with WHSSC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.5 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.7 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.

1.3.8 The Vice-Chair is accountable to the Chair for their performance as Vice Chair.

Non-Officer Members

1.3.9 Non-Officer members are accountable to the Chair for their performance as Non-Officer members.

WHSST Director of Specialised and Tertiary Services

1.3.10 The WHSST Director of Specialised and Tertiary Services (Lead Director), as head of the Management Team reports to the Chair and is responsible for the overall performance of the WHSST. The Lead Director is accountable to the Joint Committee in relation to those functions delegated to it by the Joint Committee. The Lead Director is also accountable to the Chief Executive of the host LHB in respect of the administrative arrangements supporting the operation of the team.

WHSST Directors (excluding the WHSST Director of Specialised and Tertiary Services)

1.3.11 The Medical Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, and the Nurse Director of Specialised and Tertiary Services are accountable to the Joint Committee and the Chief Executive of the host LHB through the Lead Director.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** 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. The Chair may 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.

1.4.2 The ***Vice Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.3 The appointment process for the Vice Chair and the two other Independent Members shall be determined by the Joint Committee,

subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.4 The ***WHSST Directors*** shall be appointed by the Joint Committee, and employed by the host LHB in accordance with the eligibility requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the employment policies of the host LHB, as appropriate. The appointments process shall be in accordance with the workforce policies and procedures of the host LHB and any directions made by the Welsh Ministers.

1.4.5 WHSST Directors tenure of office as Joint Committee members will be determined by their contract of employment.

1.4.6 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

1.4.7 The Joint Committee will require its Chair and WHSST Directors to confirm their continued eligibility on an annual basis in writing.

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of specialised services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the WHSST acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

2.0.5 The LHB Chairs *[through the lead Chair]* shall put in place arrangements to meet with the Joint Committee Chair on a regular basis to discuss the Joint Committee's activities and operation.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these WHSSC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee'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 Joint Committee;
ii. Scheme of delegation to joint sub-Committees and others; and
iii. Scheme of delegation to Officers.

all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure

that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

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

3.2 Delegation to joint sub-Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of their functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted or to others.

3.3 Delegation to Officers

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

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Lead Director may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Directors are in turn responsible for delegation within their own teams in accordance with the framework established by the Lead Director and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

4.0.1 In accordance with WHSSC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and

assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum, it shall establish joint sub-Committees which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the joint sub-Committee structure established by the Joint Committee, including detailed terms of reference for each of these joint sub-Committees are set out in Annex 3 of these WHSSC SOs.

4.0.6 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee 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;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such joint sub-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 Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the joint sub-Committee's defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set in WHSSC Standing Order 4.0.9) or others.

4.0.9 WHSST Directors or officers should not normally be appointed as joint sub-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. Designated WHSST Directors or officers shall, however, be in attendance at such joint sub-Committees, as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all joint sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint sub-Committee Chairs' shall bring to the Joint Committees 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 joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 6 weeks 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.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in Annex 4 of the WHSSC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee 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;
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - 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 Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Expert Panel or Advisory Group shall also submit an annual report to the Joint Committee through the Chair within 6 weeks 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.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, 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, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary 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. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Working with Community Health Councils

6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

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

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisations website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Lead Director, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall 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 Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set

of supporting papers at least 10 calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee 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 Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments (EIA) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

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

6.5.6 In the case of a meeting called by Joint Committee 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

6.5.7 Except for meetings called in accordance with WHSSC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee 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 each LHB and the Joint Committee's principal sites;
- On each 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 Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each 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.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

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

6.6.2 The Joint Committee 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 affecting a WHSST officer or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee 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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

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

6.6.4 The Committee Secretary, on behalf of the Joint Committee 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.

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee 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.

Addressing the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee 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.

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

Quorum

6.6.10 At least 8 voting members, at least 4 of whom are LHB Chief Executives and 2 are Independent Members, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have

delegated voting rights.

6.6.12 If the Lead Director or another WHSST Director is unable to attend a Joint Committee 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, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g., a person deputising for the Lead Director will usually be another WHSST Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy 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. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee 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 Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee 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 Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 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 Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee 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 Joint Committee business.

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

6.6.18 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.

6.6.19 **Motions under discussion –** When a motion is under discussion, any Joint Committee 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 Joint Committee member may not be heard further;
- The Joint Committee 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.

6.6.20 **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.

6.6.21 **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 Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee 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 Joint Committee members.

6.6.23 A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/WHSSC Director to which a matter has been

referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee 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 Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the Chairs of the LHB's Advisory Groups. .

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of a WHSST member vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in

accordance with any legislative requirements, e.g., Data Protection Act, the Joint Committee's Communication Strategy and the host LHB's Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate members), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee 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 Joint Committee Chair or relevant joint sub-Committee or group, 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 **[To insert title of policy of relevant policy]** or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour 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 Joint Committee, including Joint Committee members, WHSST officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the WHSSC SOs.

7.1 Declaring and recording Joint Committee members' interests

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

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and

the Joint Committee 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 Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

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

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee 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 Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the host LHB's website.

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

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's

meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary before the start of the Joint Committee 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 Joint Committees minutes.

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

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where *[insert relevant example];*

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

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

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

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee 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 Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee 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 Joint Committee member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee 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 Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 **The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The WHSSC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Lead Director, establishes and maintains a system for the declaration, recording and handling of WHSST officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[2] hospitality and sponsorship

7.5.1 The Values and Standards of Behaviour Framework **[**the **insert title of**

[1] 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.

[2] The term gift refers also to any reward or benefit.

WHSSC policy/and or procedure] adopted by the Joint Committee prohibits Joint Committee members and WHSST 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.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or WHSST 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 Joint Committee member or WHSST 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 Committee 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 Joint Committee;

- **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, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; 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 must always be declined.

7.5.4 A distinction shall 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 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** [WHSSC to insert title of relevant policy] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Joint Committee members. WHSST Directors will adopt a similar mechanism in relation to WHSST officers working within their areas.

7.7.2 Every Joint Committee member and WHSST officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Lead Director, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regard to gifts and hospitality, individuals must apply the following principles, subject to the considerations in WHSSC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded.

Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and WHSST 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 Joint Committee;
- 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.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of 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.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

[3] 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.

8.1.1 The Joint Committee 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 others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, expert panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within six weeks 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-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee 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 Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee 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 Joint Committee itself may commission specifically

for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these WHSSC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders 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 citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the WHSST, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its

relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The WHSSC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in WHSSC SOs, including the appropriate impact assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Introduction

As set out in WHSSC Standing Order 3, the Welsh Health Specialised Services Committee (the Joint Committee) - 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 Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i. A sub-Committee of the Joint Committee, e.g., Audit Committee;

ii. A Group, Expert Panel or Advisory Group , e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii. Officers of the Joint Committee (who may, subject to the Joint Committee'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 Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee'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 Joint Committee;
- Scheme of delegation to sub-Committees or sub-Groups and others; and
- Scheme of delegation to officers.

all of which form part of the WHSSC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee 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 Joint Committee unless it is specifically delegated in accordance with the requirements set out in WHSSC SOs or WHSSC SFIs***

- ***The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Joint Committee 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 Joint Committee 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***

- ***The Joint Committee may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Joint Committee 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 Joint Committee

The Joint Committee 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 Lead Director

The Lead Director 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 Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Lead Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in WHSSC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Lead Director may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee 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; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee'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 **[Joint Committee to insert details]** 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 Joint Committee has set out alternative arrangements.

If the Lead Director is absent their nominated Deputy may exercise those powers delegated to the Lead Director on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Lead Director 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 Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: **[Joint Committee to insert details]**
3	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 Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING	Vary, amend and recommend for approval to the Boards of the Local Health Boards:

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements.

		ARRANGEMENTS	▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	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 Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance with WHSSC Standing Order requirements

9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with WHSSC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve policies for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with WHSSC SFIs
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and officers
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the Management Team and any other Joint Committee level appointments, e.g., the Committee Secretary
15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee

18	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
19	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
20	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
21	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
23	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
24	FULL	STRATEGY & PLANNING	Approve the Joint Committee's citizen engagement and involvement strategy, including communication
25	FULL	STRATEGY & PLANNING	Approve the Joint Committee's partnership and stakeholder engagement and involvement strategies

26	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
27	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
28	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
29	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
30	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans

32	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the Joint Committee's external auditor and approve action required, including improvement plans
35	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the Joint Committee's performance against Healthcare Standards for Wales and approve action required, including improvement plans
36	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government
37	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		**[insert details]** in accordance with statutory and Welsh Government requirements
	VICE CHAIR		**[insert details]** in accordance with statutory and Welsh Government requirements
	CHAMPION/ NOMINATED LEAD		**[insert details]** in accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[5]

WHSSC Standing Order 3 provides that the Joint Committee may delegate powers to sub-Committees and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including **[insert details]**

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

- **[insert details]**

- **[insert details]**

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to sub-Committees.

[5] As defined in Standing Orders.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

The WHSSC SOs and WHSSC SFIs specify certain key responsibilities of the Lead Director, the Director of Finance and other officers. The Lead Director's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other WHSST Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the WHSSC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Joint Committee to determine]	**[Joint Committee to determine]**

This scheme only relates to matters delegated by the Joint Committee to the Lead Director and other WHSST Directors, together with certain other specific matters referred to in WHSSC SFIs.

Each WHSST Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these WHSSC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***WHSSC SFIs***
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents [Joint Committee to insert details]***

agreed by the Joint Committee. These documents must be read in conjunction with the WHSSC SOs and will have the same effect as if the details within them were incorporated within the WHSSC SOs themselves.

These documents may be accessed by:

[Joint Committee to insert details]

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 www.wales.nhs.uk/governance-emanual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each sub-Committee]

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each Advisory Group and Expert Panel]

Schedule 4.2

MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

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. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee's (the EASC or the Joint Committee) proceedings and business. These EASC Standing Orders (EASC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated [26 September 2017] made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated [26 September 2017] between the Joint Committee and **[Insert name of host]** (the host LHB), form the basis upon which the Joint Committee governance and accountability framework is developed. Together with

the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and Emergency Ambulance Services Team (EAST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee.

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 Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Emergency Ambulance Services Committee (Wales) Regulations 2014** (the EASC Regulations). The functions and services of the Joint Committee are listed in the **Emergency Ambulance Services Committee (Wales) Directions 2014,** (EASC Directions) and are subject to variations to those functions agreed from time to time by the Joint Committee**.** The Directions were amended by the **Emergency Ambulance Services Committee (Wales) Amendment Directions 2016.** The Joint Committee is hosted by the **[insert name of host]** on behalf of each of the seven LHBs.

ii) The principal place of business of the EASC is **[insert address]**

iii) All business shall be conducted in the name of the Emergency Ambulance Services Committee on behalf of LHBs.

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** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) 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 LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The EASC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance and non-emergency patient transport services and for the purpose of jointly exercising those functions will establish the joint committee.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the EASC Regulations, which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The **[insert name of host]**, as the host LHB shall issue an indemnity to the Chair, on behalf of the LHBs.

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it 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.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and 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.

xiv) The Welsh Ministers, reflecting their constitutional and legal obligations under the **Well-being of Future Generations (Wales) Act 2015 (2015 No.02)**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xv) The **Well-being and Future Generations (Wales) Act** also places duties

on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

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

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation (The Cwm Taf University LHB Scheme of Delegation has been adopted for use by the Committee in November 2016) to others;
- The EASC SFIs (The Cwm Taf Standing Financial Instructions have been adopted for use by the Committee in November 2016);
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) **Annex 2** to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with these EASC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the EAS Team and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these EASC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in **Annex 2** of these SOs.

Applying EASC Standing Orders

xx) The EASC SOs (together with the EASC SFIs and other documents making up the governance and accountability framework) will, as far as they are

applicable, also apply to meetings of any Joint Committee Sub Groups established by the Joint Committee, including any Advisory Groups. The EASC SOs may be amended or adapted for the Joint Committee Sub Groups or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on Joint Committee Sub Groups and Advisory Groups may be found in Annexes 3 and 4 of these EASC SOs, respectively.

xxi) Full details of any non-compliance with these EASC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee at [**insert name of host]** to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with EASC SOs is a disciplinary matter.**

Variation and amendment of EASC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the EASC SOs, the Chair of the Joint Committee 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 should take appropriate advice from the Committee Secretary.

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

Relationship with LHB Standing Orders

xxv) The EASC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

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

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, Joint Committee Sub Groups and Advisory Groups;
- Ensuring that Joint Committee 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 Joint Committee 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 Joint Committee's compliance with the law, EASC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committees operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – EASC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the commissioning of emergency ambulance and non-emergency patient transport services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of emergency ambulance and non-emergency patient transport services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the EAS Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the

outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the EAS Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee

1.2.1 The membership of the Joint Committee shall be 9 voting members and three associate members, comprising the *Chair* (appointed by the Welsh Ministers) and the *Vice-Chair* (appointed by the Joint Committee from existing chief officer (executive) or nominated representatives of the seven LHBs), together with the following:

Chief Officers or nominated representative

1.2.2 A total of 7, drawn from each Local Health Board in Wales. (Where a Chief Officer intends to nominate a representative the nomination must be an Officer Member (Executive Director) of the LHB, must be in writing addressed to the Chair of the Joint Committee and must specify if the nomination is for a specific length of time.

Officer Member

1.2.3 An officer member employed by [**insert name of host**] (the host LHB) to undertake the functions of the Chief Ambulance Services Commissioner. In addition,

1.2.4 Where a post of Chief Ambulance Services Commissioner 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 Joint Committee 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.

Associate Members

1.2.5 The following three Associate Members who will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust;
- Chief Executive of the Welsh Ambulance Services NHS Trust;
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.6 The Joint Committee Chair may invite other members of the EAS Team or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.3 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with EASC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.4 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.5 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on

its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.6 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.

1.3.7 The Vice-Chair is accountable to the Chair for their performance as Vice-Chair.

Officer Members

1.3.8 Officer members are accountable to the Chair for their performance.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** 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. The Chair may 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.

1.4.2 The ***Vice-Chair*** shall be appointed by the Joint Committee from amongst the Chief Executives or their nominated representatives of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than four 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.

1.4.3 Reference to the tenure of office of the Vice-Chair are to this appointment and not to their tenure of office as a member of the Joint Committee.

1.4.4 The appointment process for the Vice-Chair shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.5 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they applicable, and as specified in the relevant regulations. Any

member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of emergency ambulance or non-emergency patient transport services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the EAS Team acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chief Officer.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these EASC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee'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 Joint Committee;
ii. Scheme of delegation to Joint Committee Sub Groups and others; and

Scheme of delegation to Officers all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Chief Ambulance Services Commissioner, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Joint Committee Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Chief Ambulance Services Commissioner has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair and/or Assistant Chief Ambulance Services Commissioner will take a decision on the urgent matter, as appropriate.

3.2 Delegation to Joint Committee sub Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of their functions to Joint Committee sub-Committees or sub-Groups or others, setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by Joint Committee sub-Committees or sub-Groups which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Chief Ambulance Services Commissioner (CASC). For these aspects, the CASC, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The CASC will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Ambulance Services Commissioner may periodically propose amendments to the Scheme of Delegation and any such amendments must also be considered

and approved by the Joint Committee.

3.3.3 Individual Chief Officers are in turn responsible for delegation within their own teams in accordance with the framework established by the Chief Ambulance Services Commissioner and agreed by the Joint Committee.

4. JOINT COMMITTEE SUB-COMMITTEES AND SUB-GROUPS

4.0.1 In accordance with EASC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint sub-Committees and sub-Groups of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a Joint Committee sub-Committee and sub-Groups structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum it shall establish joint –sub-Committee which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own Joint Committee sub-Committee or sub-Groups or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the Joint Committee sub-Committee or sub-Groups structure established by the Joint Committee, including detailed terms of reference for each of these Joint Committee sub-Committees or sub-Groups are set out in **Annex 3** of these EASC SOs.

4.0.6 Each Joint Committee sub-Committee or sub-Group established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee 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;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Joint Committee Sub-Groups, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such Joint Committee sub-Committee or sub-Group - 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 Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the Joint Committee sub-Committees' or sub-Groups' defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set out in EASC SOs 4.0.9) or others.

4.0.9 Members of the EAS Team should not normally be appointed as Joint sub-Committee Chair, nor should they be appointed to serve as members of any sub-Committee set up to review the exercise of functions delegated to officers. Designated EAS Team officers shall, however, be in attendance at Joint sub-Committees/groups as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all Joint Committee sub-Committees and sub-Groups and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint Committee sub-Committee and sub-Group Chairs' shall bring to the Joint Committees 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 Joint Committee sub-Committee and sub-Group shall also submit an annual report to the Joint Committee through the Chair within - six weeks 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.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in **Annex 4** of the EASC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee 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;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - 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 Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Sub Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Sub Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Sub Group shall also submit an annual report to the Joint Committee through the Chair within six weeks 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.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, 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, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary 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. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

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

6.2.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of Joint Committee sub-Committees or sub-Groups, Expert Panel and Advisory Groups.

6.2.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisations website.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

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

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Ambulance Services Commissioner, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from Joint Committee Sub Group and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.4.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall 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 Joint Committee business.

Notifying and equipping Joint Committee members

6.4.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Joint

Committee meeting. This information may be provided to Joint Committee 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 Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.4.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee 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 Joint Committee 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 EASC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee 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 each LHB and the Joint Committee's principal sites; On each 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 Joint Committee's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, each 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 Joint Committee Meetings

Admission of the public, the press and other observers

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

6.5.2 The Joint Committee 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 affecting an EAS team member or a patient.

In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee 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 [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].'*

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

6.5.4 The Committee Secretary, on behalf of the Joint Committee 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 Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee'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 Joint Committee 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.

Addressing the Joint Committee, its Joint Committee Sub-Groups, Expert Panel or Advisory Groups

6.5.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its Joint Committee sub-Committees or sub-Groups, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.5.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee 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 Chief Executives present will agree who will preside.

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

Quorum

6.5.10 At least four voting members, whom are LHB Chief Executives, must be present to allow any formal business to take place at a Joint Committee meeting.

6.5.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a representative/deputy to attend on their behalf. The nominated representative/deputy should be an Officer Member (Executive Director) of the same organisation. Nominated representatives/deputies will formally contribute to the quorum and will have delegated voting rights.

6.5.12 If the Chief Ambulance Services Commissioner or another Associate Member is unable to attend a Joint Committee 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, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g. a person deputising for the Chief Ambulance Services Commissioner will usually be the Assistant Chief Ambulance Services Commissioner, they will not have any voting rights.

6.5.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their nominated deputy/representative 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. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.14 In the normal course of Joint Committee 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 Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee 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 Joint Committee unless moved by a Joint Committee member or their deputy/representative and seconded by another Joint Committee member or their deputy/representative (including the Joint Committee Chair).

6.5.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee 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 Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.16 The Joint Committee 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 Joint Committee business.

6.5.17 **Amendments –** Any Joint Committee member or their deputy/representative may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.5.18 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.

6.5.19 **Motions under discussion** – When a motion is under discussion, any Joint Committee member or their deputy/representative 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 Joint Committee member may not be heard further;
- The Joint Committee 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.

6.5.20 **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.

6.5.21 **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 Joint Committee Chair.

6.5.22 **Motion to rescind a resolution –** The Joint Committee 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 Joint Committee members.

6.5.23 A motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a Joint Committee sub-Committee or sub-Group /EASC Director to which a matter has been referred.

Voting

6.5.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require

a secret ballot or recorded vote if the majority of voting Joint Committee 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 Joint Committee.

6.5.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales.

6.5.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.5.27 A nominated deputy/representative of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of the Chief Ambulance Commissioner vote. Absent Joint Committee members may not 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 Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, 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 Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Freedom of Information Act, the Joint Committee's Communication Strategy and the [**Insert host body]** Welsh language requirements.

6.7 Confidentiality

6.7.1 All Joint Committee members (including Associate members), together with members of any Joint Committee sub-Committee or sub-Group, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of

all matters considered by the Joint Committee 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 Joint Committee Chair or relevant Joint Committee sub-Committee or sub-Group or group, 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, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour 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 Joint Committee, including Joint Committee members, EAS Team officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the EASC SOs. The Values and Standards of Behaviour document is the same as the Welsh Health Specialised Services Joint Committee.

7.1 Declaring and recording Joint Committee members' interests

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

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee 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 Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Chief Ambulance Services Commissioner,

through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee 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 Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This will include publication on the EASC website.

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

7.2 Dealing with Members' interests during Joint Committee meetings

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

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary before the start of the Joint Committee 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 Joint Committees minutes.

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

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where *[insert relevant example];*

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

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

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

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee 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 Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee 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 Joint Committee member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee 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 Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 The **Local Health Boards (Constitution, Membership and Procedures)**

[1] 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.

(Wales) Regulations 2009 define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The EASC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Chief Ambulance Services Commissioner, establishes and maintains a system for the declaration, recording and handling of EAS Team officers' interests in accordance with the Values and Standards of Behaviour Framework. This will be done in conjunction with the declarations of interest recorded by the Welsh Health Specialised Services Committee which is also hosted by **[Insert name of Host Body]**

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[2] hospitality and sponsorship

7.5.1 The Values and Standards of Behaviour Framework [the **insert title of EASC policy/and or procedure]** adopted by the Joint Committee prohibits Joint Committee members and EAS Team officers 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.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or EAS Team 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 Joint Committee member or EAS Team officer. Failure to observe this requirement may result in disciplinary and/or legal action.

[2] The term gift refers also to any reward or benefit.

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 Committee 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 Joint Committee;

- **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, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; 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 must always be declined.

7.5.4 A distinction shall 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 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship

may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** [LHB to insert title of relevant policy] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts, hospitality and sponsorship made to Joint Committee members. The EAS Team officers will adopt a similar mechanism in relation to **[Insert name of host body]** staff working within their areas.

7.7.2 Every Joint Committee member and EAS Team officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Chief Ambulance Services Commissioner, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regards to gifts and hospitality, individuals must apply the following principles, subject to the considerations in EASC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and EAS Team 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 Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,

[3] 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.

- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of 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.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee 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 others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Joint Committee Sub Group, expert panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each Joint Committee Sub Group and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within six weeks 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-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee 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 Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee 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 Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these EASC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders 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 citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the Emergency Ambulance Services Team (EAST), individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The EASC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in EASC SOs, including the appropriate impact assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Introduction

As set out in EASC Standing Order 3, the Emergency Ambulance Services Committee (the Joint Committee) - 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 Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i) A sub-Committee of the Joint Committee e.g., Audit Committee;

ii) A Group, Expert Panel or Advisory Group, e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii) Officers of the Joint Committee (who may, subject to the Joint Committee'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 Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee'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 Joint Committee;
- Scheme of delegation to Joint Committee sub-Committee or sub Group and others; and
- Scheme of delegation to officers.

all of which form part of the EASC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee 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 Joint Committee unless it is specifically delegated in accordance with the requirements set out in EASC SOs or EASC SFIs**

- **The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management**

- **Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility**

- **The Joint Committee 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 Joint Committee 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**

- **The Joint Committee may delegate authority to act, but retains overall responsibility and accountability**

- **When delegating powers, the Joint Committee 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 Joint Committee

The Joint Committee 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 Ambulance Services Commissioner

The Chief Ambulance Services Commissioner 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 Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Ambulance Services Commissioner will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in EASC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Chief Ambulance Services Commissioner may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee 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; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee'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 [**Joint Committee to insert details]** 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 Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

The Quality and Safety Committee [Committee name to be inserted]

The Quality and Safety Committee [title to be inserted] will provide assurance to the Joint Committee of the effectiveness of its arrangements for managing quality and safety.

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; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee'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 **[Joint Committee to insert details]** 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 Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner 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 Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with EASC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: • Collaborative Commissioning Framework Agreement(s) • EAS Integrated Medium Term Plan
3	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 Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ EASC SOs ; ▪ EASC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements.

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	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 Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Ambulance Services Commissioner in accordance with EASC Standing Order requirements
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with EASC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Ambulance Services Commissioner and officers
11	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
12	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments, e.g., the Committee Secretary
13	FULL	ORGANISATION	Require, receive and determine action in response to the declaration of Joint

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
		STRUCTURE & STAFFING	Committee members' interests, in accordance with advice received, e.g. From Audit Committee
14	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-groups, including any joint sub-groups directly accountable to the Joint Committee
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Joint Committee sub-groups, or Group set up by the Joint Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
17	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all Joint Committee sub-groups, and groups established by the Joint Committee
18	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
19	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
20	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
21	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Commissioning Plan and Population Health Needs Assessment ▪ The development and delivery of emergency ambulance and non-emergency patient Transport services for the population of Wales

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
23	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Ambulance Services Commissioner set out in the EASC SFIs
24	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
25	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's EAS Team on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
26	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee sub-groups, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
27	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-groups (as appropriate)
28	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
29	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the Joint Committee's external auditor and approve action required, including improvement plans

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
30	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the Joint Committee's performance against Healthcare Standards for Wales and approve action required, including improvement plans
31	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Assembly Government
32	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR AND VICE-CHAIR			
34	CHAIR		In accordance with statutory and Welsh Government requirements
35	VICE-CHAIR		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[5]

EASC Standing Order 3 provides that the Joint Committee may delegate powers to sub-groups and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Groups; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

[sub-Committees and sub-Groups to be inserted]

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Group terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to Joint Committee Sub Groups.

[5] As defined in Standing Orders

SCHEME OF DELEGATION TO EMERGENCY AMBULANCE SERVICES TEAM AND OFFICERS

The EASC SOs and EASC SFIs specify certain key responsibilities of the Chief Ambulance Services Commissioner, the Director of Finance (WHSSC/EASC) and other officers. The Chief Ambulance Services Commissioner's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other EAS Team level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, set out in detail, together with the schedule of additional delegations below and the associated financial delegations set out in the EASC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Joint Committee to determine]	**[Joint Committee to determine]**

This scheme only relates to matters delegated by the Joint Committee to the Chief Ambulance Services Commissioner and other members of the EAS Team together with certain other specific matters referred to in EASC SFIs. In November 2016, the Joint Committee agreed to use the host body's Standing Financial Instructions (Cwm Taf) and Scheme of Delegation.

Each member of the EAS Team is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated (aligned to the arrangements of the host body).

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these EASC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***EASC SFIs***
- ***Scheme of Delegation***
- ***Values and Standards of Behaviour Framework***
- ***Risk Register***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the EASC SOs and will have the same effect as if the details within them were incorporated within the EASC SOs themselves.

These documents may be accessed by:

EASC Website http://www.wales.nhs.uk/easc/the-committee

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 www.wales.nhs.uk/governance-emanual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE SERVICES COMMITTEE Standing Orders

Sub Groups

[To be inserted]

Terms of Reference

Annex 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Terms of Reference to be included when available

Practice Note: Acceptance, Implementation and Monitoring of Audit Recommendations

Introduction

This Practice Note has been produced by the Audit Committee (referred to hereafter as 'the Committee') to provide a reporting framework for monitoring the acceptance and implementation of audit recommendations in accordance with agreed timescales. More specifically, it is also intended to clarify the reporting expectations of the Committee and the information required in support of any progress update or any request for implementation deadlines to be extended.

Acceptance and Implementation of Audit Recommendations

In considering this note it is important to remember that the Committee would expect all audit reviews to be conducted and reported to Committee with the full support of nominated Health Board staff.

Audit recommendations should be framed in a way which broadly meets the requirements of widely recognised SMART principles (i.e. they should be specific, measurable, achievable, realistic and timebound).

As a further matter of principle, the Committee would normally expect all recommendations to be accepted. However, no recommendation or timescale should be accepted unless the 'Responsible Officer' (RO) fully understands and is confident that the agreed actions are appropriate, can be delivered in practice and provide value for money. Officers should use the draft report clearance system to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations.

It is also important to assess, at an early stage, whether the recommendations can be actioned by the Health Board alone or whether implementation is outside of the Health Board's direct control because of the involvement and dependency on third parties. Such situations should be made clear at the outset (to both auditors and the Committee) and should be formally recorded in updates to the tracking register.

Auditors would be expected to highlight to officers any concerns they might have about the initial management response e.g. whether the response is specific, realistic and properly addresses the recommendations proposed.

Officers would also be expected to provide their management response in accordance with the timescales agreed with auditors to help avoid protracted delays in the reporting of agreed audit findings to Committee.

In summary, any differences of opinion regarding the applicability, relevance, practicality or timeliness of recommendations should be fully discussed between auditors and the RO (and the Executive Lead if deemed necessary) prior to it being submitted for consideration by the Committee. If an agreed way forward cannot be found, the issue(s) should be referred to

the Committee for further consideration and discussion. The Committee anticipates that such occurrences are likely to be rare.

Once the recommendations and timescales have been accepted the Committee expects the recommendations to be implemented as agreed.

Report to Audit Committee

Regular progress reports regarding the implementation of agreed recommendations are required to be submitted by the RO/Executive Lead (through the Board's Secretary's Office) to the Committee for monitoring and scrutiny purposes by updating the 'Audit Committee Tracking Register'.

As a minimum, updates should provide details of progress made since the date of the last Committee meeting, obstacles to further progress and confirmation, or otherwise, that progress to achieve the agreed implementation dates remain on track. In doing so, it is important to keep in mind the specific action required as set out in the original recommendation or in the agreed management response.

The Committee will expect to be given 'early warning' of any recommendations that are likely to miss their agreed implementation date. Updates should provide an explanation for the delay, details of the action to be taken to address the situation as quickly as possible and, where necessary, a request for the Committee to consider and approve a revised implementation timetable.

Where the implementation of a 'high risk' action is delayed beyond 3 months of the originally agreed date the responsible Executive Lead will be invited to attend the next meeting of the Committee to discuss the various issues involved.

Once all recommendations have been implemented to the satisfaction of the Committee they will be classified as closed and the actions and supporting statements formally removed from the 'live' tracking register.

Finally, It would be very helpful if RO's/Executive Leads could provide, where it is possible to do so, some indication of the impact the recommendations have had on the Health Board in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, increased security or better use of resources etc.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.7** **28 October 2019**

Audit Committee Report
SCHEME OF DELEGATION REPORT

Executive Lead: Director of Finance
Author: Acting Head of Finance (Financial Accounts)
Contact Details for further information: Liz Williams on 01443 443803 or Elisabeth.williams@wales.nhs.uk

Purpose of the Audit Committee Report
To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.06.19 to 31.8.19; 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 2019-2022 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: a) **NOTE** the position on procurement matters for the 1.06.19 to 31.8.19; b) **NOTE** the update regarding Purchase to Pay. c) **APPROVE** the revision to the Scheme of Delegation						

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:

- To report transactions approved as "exceptions" within the Scheme of Delegation for the period 1.06.19 to 31.8.19

- 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).

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 1.06.19 to 31.08.19.

The report also provides an update on the Prompt Payment compliance for 2019-20.

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 1.06.18 to 31.08.19.

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 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 1.06.19 to 31.8.19.

Table A – Single Tender Actions 1.06.19 to 31.8.19

STA	Division	Contract description	Supplier	Contract Value exc. VAT	Reason for approval	Date Returned
SQT1082	Radiology	Maintenance contract for Radiology Equipment	Mount International United Services Ltd	£40,499	Service/work is follow-up, supplier has already undertaken initial work in same area (work undertaken via open competition).	28.06.19
SQT1090	Medical Personnel	Overseas travel & accommodation	Dial A Flight	£40,000	Need to retain particular contractor for real business continuity issues; not preferences. (additional information below)	01.08.19
SQT1092	Medicine	Dexa Licences	RioMed	£62,579	Compatibility issue	21.08.19

Single Quotation Tender (SQT)1090 – BAPIO NHS Wales initiative to recruit Doctors from India. Due to the nature of the work Dial A Flight has the knowledge, expertise and contacts required to accommodate and organise the management of the All Wales recruitment team recruitment drive in India. Costs were benchmarked and were in line with availability, the contacts and expertise of organising the events led this to an SQT.

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

There were no contracts requiring ministerial approval during this period.

3.2. Purchase to Pay (P2P)

	0 - 30 Days		Total		%	
	Number	Value	Number	Value	Number	Value
Apr-19	12,058	23,196,053	12,537	24,072,353	96.2%	96.4%
May-19	12,264	30,891,106	13,005	33,166,671	94.3%	93.1%
June-19	19,432	28,858,797	20,146	31,480,893	96.5%	91.7%
July-19	17,502	29,484,876	18,180	30,453,145	96.3%	96.8%
Aug-19	19,803	36,266,318	20,416	38,185,523	97.0%	95.0%
YTD	81,059	148,697,149	84,284	157,358,585	96.2%	94.5%

The Health Board is meeting its 95% target of paying non-NHS invoices within 30 days during 2019/20, with an accumulated position for the year of 96.2% (94.5% in value terms). This compares to 96.0% (value 95.7%) in 2018/19.

The NHS invoice position shows that 75.9% of invoices were paid within 30 days for the year to date. (74.7% in 2018/19).

Work continues, both locally and as part of the All Wales P2P Forum, in conjunction with NWSSP, to improve current processes and procedures and address issues that arise in the P2P process.

3.3 Scheme of Delegation/Financial Control Procedures

A review has been undertaken of the Scheme of Delegation mainly in respect of Continuing Healthcare (CHC) packages and items which currently require Chief Executive Officer (CEO) approval. The Scheme of delegations for other Health Boards were considered as part of this review.

Appendix A outlines the existing limits and delegated authority together with the proposed changes – highlighted in red.

It is recognised that a comprehensive review of the Standing Financial Instructions (SFIs), Scheme of Delegation and Financial Control Procedures will need to be carried out following the Bridgend Boundary change and as part of the implementation of the new operating framework and organisational structure.

4. RECOMMENDATION

The Audit Committee is asked to:

a) **NOTE** the position on procurement matters for the period 1.06.19 to 31.08.19;

b) **NOTE** the update regarding Purchase to Pay.

c) **APPROVE** the revision to the Scheme of Delegation

Freedom of information status	Open

Proposed changes to the Additional delegations linked to the SFIs **Appendix A**

SoD version 9 Ref.	SoD version 9 Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed	
				Limits	Authority delegated to:	Limits	Authority delegated to:
9 A4	17	**Individual Continuing Healthcare Placements / Packages**	**Authorisation of Individual placements/packages following recommendation from CHC Panel**	**Annual value up to £45k**	**Chair of CHC Panel**	**Annual value up to £45k**	**Chair of CHC Panel**
				Annual value between £45k and £60k	**Director of Nursing**	**Annual value between £45k and £150k**	**Relevant Executive Director**
				Annual value over £60k	**Chief Executive and Director of Finance**	**Annual value over £150k**	**Chief Executive and Director of Finance**
10 B6	20	**Engage non-medical, non-payroll staff (subject to contacting and tax assurance rules) -** Director of W&OD & Head of Procurement to confirm agreement of off contract hires prior to any commitment)		**Below £10k gross commitment**	**Directorate Manager**	**Below £10k gross commitment**	**Directorate Manager**
				£10k to £25k gross commitment	**Deputy/Assistant Director**	**£10k to £25k gross commitment**	**Deputy/Assistant Director**
				up to £50k gross commitment	**Executive Directors**	**up to £100k gross commitment**	**Executive Directors**
				Over £50k gross commitment	**Chief Executive**	**Over £100k gross commitment**	**Director of Finance or Chief Executive**
11 A	24	**Non Pay expenditure**	**Oracle Requisitions**	**Below £1.5k**	**Nominated budget holder for specific cost centre**	**Below £1.5k**	**Nominated budget holder for specific cost centre**
				£1.5k to £5k	**Head of Department or equivalent**	**£1.5k to £5k**	**Head of Department or equivalent**
				up to £25k	**Directorate Manager or equivalent**	**up to £25k**	**Directorate Manager or equivalent**
				up to £50k	**Assistant/Deputy Director**	**up to £100k**	**Assistant/Deputy Director**
				up to £100k	**Executive Director**	**up to £250k**	**Executive Director**
				up to £500k	**Director of Finance**	**up to £500k**	**Director of Finance**
				Over £500k	**Chief Executive**	**Over £500k**	**Chief Executive**
11 A	25	**Non Pay expenditure**	**Legal Claims and Defence costs**	**Below £1.5k**	**Head of Patient Experience**	**Below £1.5k**	**Head of Patient Experience**
				Below £5k	**Head of Patient Experience**	**Below £5k**	**Head of Patient Experience**
				Below £20k	**Assistant Director Quality and Patient Experience**	**Below £50k**	**Assistant Director Quality and Patient Experience**
				Below £50k	**Director of Nursing and Quality**	**Below £100k**	**Director of Nursing and Quality**
				Over £50k	**Chief Executive**	**Over £100k**	**Director of Finance or Chief Executive**
11 C	26	**Non Pay expenditure**	**Quotations and tenders**	**Up to £5k**	**Head of Department**	**Up to £5k**	**Head of Department**
				£5k to £24.9k	**Head of Procurement or Director of Finance or Chief Executive**	**£5k to £24.9k**	**Head of Procurement**

SoD version 9 Ref.	SoD version 9 Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing Limits	Cwm Taf Morgannwg existing Authority delegated to:	Cwm Taf Morgannwg proposed Limits	Cwm Taf Morgannwg proposed Authority delegated to:
				£25k to OJEU threshold for supplies and services	Single tender action authorised by Chief Executive	£25k to OJEU threshold for supplies and services	Single tender action authorised by Director of Finance
				£25k to £1m for Works	Single tender action authorised by Chief Executive	£25k to £1m for Works	Single tender action authorised by Director of Finance
				OJEU threshold for supplies and services to £1m	Single tender action prohibited	OJEU threshold for supplies and services to £1m	Single tender action prohibited
				Above OJEU threshold for works	Single tender action prohibited	Above OJEU threshold for works	Single tender action prohibited
				Over £1m (Other than D4L)	Welsh Government	Over £1m (Other than D4L)	Welsh Government
12 C	31	Capital orders and payment authorisation	Enter lease arrangement (all types) total value			up to £25k	Head of Finance
				up to £50k	Director of Finance	Over £25k	Director of Finance
				over £50k	Chief Executive, Director of Finance and relevant Director		
14 B1	36	Approve losses, write-offs and compensation payments due to:	losses of cash (theft, fraud, etc)	within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive	within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive
14 B1	36	Approve losses, write-offs and compensation payments due to:	damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (theft, fraud, arson)	within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive	Up to £25k	Director of Finance
						within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive
14 B1	36	Approve losses, write-offs and compensation payments due to:	extra contractual payments to contractors	within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive	within delegated limits issued by Welsh Government - £50k	Director of Finance
14 B1	36	Approve losses, write-offs and compensation payments due to:	ex-gratia payments to patients and staff for loss of personal effects	within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive	Up to £10k	Director of Nursing
						within delegated limits issued by Welsh Government - £50k	Chief Executive / Deputy Chief Executive
14 B1	36	Approve losses, write-offs and compensation payments due to:	fruitless payments including abandoned capital schemes	delegated limits £250k	Chief Executive / Deputy Chief Executive	Up to £50k	Director of Finance
						delegated limits £250k	Chief Executive / Deputy Chief Executive
14 B1	36	Approve losses, write-offs and compensation payments due to:	ex-gratia payments - voluntary release payment to staff	within delegated limits issued by Welsh Government £50,000	Remuneration Committee	within delegated limits issued by Welsh Government £50,000	Remuneration Committee
14 B1	36	Approve losses, write-offs and compensation payments due to:	bad debts and claims abandoned	Below £1k	Head of Finance	Below £1k	Head of Finance
				£1k to £10k	Deputy Director of Finance	£1k to £10k	Deputy Director of Finance
				£10k to £25k	Director of Finance	£10k to £25k	Director of Finance
				£25k to £50k	Chief Executive	£25k to £50k	Chief Executive

SoD version 9 Ref.	SoD version 9 Page No.	Main Task	Sub Task	Cwm Taf Morgannwg existing		Cwm Taf Morgannwg proposed	
				Limits	Authority delegated to:	Limits	Authority delegated to:
				over £50k	WG	over £50k	WG
14 B2	37	Approve compensation payments made under legal obligation	Personal injury and medical negligence claims	up to £5k	Head of Patient Experience	up to £5k	Head of Patient Experience
				£5k to £20k	Assistant Director Quality and Patient Experience	£5k to £20k	Assistant Director Quality and Patient Experience
				£20k to £50k	Director of Nursing	£20k to £500k	Director of Nursing
				£50k to £1m	Chief Executive	Over £500k	Chief Executive
				Over £1m	Welsh Government	Over £1m	Welsh Government
14 B2	37	Approve compensation payments made under legal obligation	Employment matters	up to £20k	Deputy Director of Workforce & OD	up to £20k	Deputy Director of Workforce & OD
				£20k to £50k	Director of Workforce & OD	£20k to £50k	Director of Workforce & OD
				over £50k	Chief Executive	over £50k	Chief Executive
14 B2	37	Approve compensation payments made under legal obligation	Other matters		Chief Executive		Chief Executive
14 B3	37	Approve Compensation payments made without legal obligation		within delegated limits issued by Welsh Government £50k	Chief Executive / Deputy Chief Executive	within delegated limits issued by Welsh Government £50k	Chief Executive / Deputy Chief Executive
17 A	41	Access to Charitable funds	Approval and setting up of designated fund signatories for new funds		Chief Executive/Deputy Chief Executive		Director of Finance
17 A	41	Access to Charitable funds	All expenditure requests for Charitable funds	up to £5k	Designated fund signatories	Up to £5k	Designated fund signatories
				Over £5k	Chief Executive / Deputy Chief Executive	£5K to £15K	Directorate Manager
						£15K to £30k	Assistant Director
						£30k to £50k	Executive Director
						Over £50k	Charitable Funds Committee
17 A	42	Investment of Charitable Funds	Placing of Investment		Chief Executive and Director of Finance		Charitable Funds Committee or Audit Committee

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.8** **28 October 2019**

Audit Committee Report
LOSSES AND SPECIAL PAYMENTS 01.06.19 TO 31.08.19

Executive Lead: Director of Finance
Author: Financial Accountant
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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 June 2019 to 31 August 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 2019-2022 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 June 2019 to 31 August 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 01.06.19 TO 31.08.19

1. SITUATION / PURPOSE OF REPORT

This report advises the Audit Committee on the losses and special payments made by the Cwm Taf Morgannwg University Health Board (CTMUHB) for the three month period from 1 June 2019 to 31 August 2019, as required in Standing Financial Instructions.

2. BACKGROUND / INTRODUCTION

The report summarises the overall financial impact of losses in the period from 1 June 2019 to 31 August 2019 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 CTMUHB. Where the WRP would be liable for a reimbursement to the CTMUHB 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 31 August 2019

This is shown in table 1 below, together with equivalent figures at the end of the last three financial years.

Table 1

	31.08.19	31.05.19	31.03.19	31.03.18	31.03.17
	£000	£000	£000	£000	£000
Medical Negligence claims/costs	87,709	80,417	81,897	78,961	68,215
Personal Injury claims/costs	456	507	532	1,618	784
Recoverable from Welsh Risk Pool	(108,207)	(99,905)	(99,137)	(87,408)	(75,527)
Net claim provision	**(20,042)**	**(18,981)**	**(16,708)**	**(6,829)**	**(6,528)**
Permanent Injury Benefit	4,525	4519	4,517	3,258	3,413
Net Provision	**(15,517)**	**(14,462)**	**(12,191)**	**(3,571)**	**(3,115)**
Number of live cases on losses system (LaSPaR)					
	31.08.19	**31.05.19**	**31.03.19**	**31.03.18**	**31.03.17**
Medical Negligence claims	347	328	317	397	502
Personal Injury claims	79	71	97	91	100

There is an increase of £7.3m in medical negligence provision during this period. £5.7m of increase is attributed to one particular case where the probability has been revised from 'Possible' to 'Certain'. The remaining increase is due to the changes in quantum estimates for a small number of cases. Corresponding increase in provision for amount recoverable from the Welsh Risk Pool is also reflected in Table 1 above.

The increase in the net claim provision is mainly due to large payments made during the period, not yet reflected in a corresponding reduction in the amount owed by the Welsh Risk Pool.

b) Expenditure incurred for the year to 31 August 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 (31.05.2019).

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
	31.8.19	**31.5.19**	**31.3.19**	**31.3.18**	**31.3.17**
	£000	**£000**	**£000**	**£000**	**£000**
Medical Negligence claims/costs	10,538	845	18,300	29,014	18,932
Personal Injury claims/costs	40	30	(405)	1,612	555
Recoverable from Welsh Risk Pool	(10,181)	(799)	(16,544)	(29,033)	(18,164)
Net claim expenditure (Note 1)	**397**	**76**	**1,371**	**1,593**	**1,323**
Permanent Injury Benefit	23	(23)	1,697	62	384
Other (Note 2)	187	4	306	174	310
Total expenditure	**607**	**57**	**3,354**	**1,829**	**2,017**

Note 1 - The annual budget for net claim expenditure for 2019-20 is £1,665k (year to date £693k). There is therefore underspend on claims of £296k included within the Health Board's position as at 31 August 2019.

The Audit Committee will also 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. Further analysis is ongoing by the WRP and we will be informed of any additional risk to the Health Board.

Note 2 – Included within the other expenditure of £187k is an amount of £165k relating to the GP Out of Hours Tax and National Insurance (NI) Payments as detailed within the attached **Appendix 4**.

UK Government's new IR35 legislation came into effect from 1 April 2017. The new legislation moved the responsibility to determine the public sector contractor's IR35 tax status from the contractors to the public sector bodies. As part of this legislation, the tax status of the GPs working within the Welsh NHS Out of Hours (OOH) services was examined by HMRC. It was concluded by HMRC that the tax status of the GPs working within this service should be that of employment rather than that of self-employment.

This ruling was challenged by the Welsh NHS bodies and during this challenge period, the Health Board continued to make payments on the previous basis.

The Health Board was not successful in this challenge and the tax status of the OOH GPs was amended mid-way through the year. It was negotiated and agreed in alliance with the GPs and other related stakeholders that the Health Board would make the payments arising from the changes in this regulation to HMRC for period 1 April 2017-30 September 2017.

In line with the scheme of delegation of duties, Welsh Government approval was received on 30 April 2019 and the payment to HMRC was made on 10 July 2019.

c) Cash Write-Offs made for the period 1 June 2019 to the 31 August 2019

Table 3 shows the cash impact for financial year 2018-19 and up to 31 August 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 HR policy, and voluntary early release payments. These are shown in **Appendix 4**.

Table 3

Cash write-offs made during 19/20

	01.06.19 - 31.08.19 £000	Previously reported £000	2019-20 £000
Medical Negligence (Appendix 1)			
Claims	1,824	1704	3,528
Costs	470	473	943
Defence Fees	107	148	255
Personal Injury (Appendix 2)			
Claims	33	42	75
Costs	19	8	27
Defence Fees	8	5	13
Permanent Injury Benefit (Appendix 3)	39	(25)	14
Other (Appendix 4)			
Ex-Gratia	16	4	20
Debt Write Off	3	0	3
Fruitless Payments	165	0	165

Employment Matter	0	0	0
Total	**2,684**	**2,359**	**5,043**
Recovered from Welsh Risk Pool	(1,079)	(31)	(1,110)
Net Cash Write-Off	**1,605**	**2,328**	**3,933**

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 June 2019 to 31 August 2019.

Medical Negligence Payments 01/06/2019 - 31/08/2019 — Appendix 1

Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
05RRSMN0039	0.00	0.00	150,000.00	0.00	150,000.00	315,000.00	465,000.00
05RVEMN0022	0.00	500.00	0.00	0.00	500.00	15,362.50	15,862.50
06RRSMN0037	0.00	236.25	0.00	0.00	236.25	9,749.32	9,985.57
12RYLMN0004	0.00	0.00	200,000.00	0.00	200,000.00	890,464.00	1,090,464.00
12RYLMN0037	0.00	6,100.00	0.00	0.00	6,100.00	20,780.00	26,880.00
13RYLMN0131	0.00	13,087.84	0.00	0.00	13,087.84	931,662.55	944,750.39
13RYLMN0160	0.00	0.00	0.00	-162,717.62	-162,717.62	187,717.62	25,000.00
14RYLMN0006	0.00	681.50	0.00	0.00	681.50	37,825.00	38,506.50
14RYLMN0010	0.00	0.00	0.00	-445,060.10	-445,060.10	470,060.10	25,000.00
14RYLMN0062	120,000.00	7,181.50	0.00	0.00	127,181.50	1,070,979.90	1,198,161.40
14RYLMN0080	0.00	0.00	0.00	-112,524.00	-112,524.00	137,524.00	25,000.00
14RYLMN0127	92,750.00	-1,164.50	0.00	0.00	91,585.50	2,737,855.99	2,829,441.49
14RYLMN0169	46,518.23	4,293.00	0.00	0.00	50,811.23	303,431.80	354,243.03
14RYLMN0178	0.00	4,165.00	0.00	0.00	4,165.00	117,514.55	121,679.55
14RYLMN0208	7,500.00	600.00	0.00	0.00	8,100.00	385,616.35	393,716.35
14RYLMN0209	0.00	0.00	0.00	-227,567.72	-227,567.72	252,567.72	25,000.00
14RYLMN0214	7,500.00	2,430.00	0.00	0.00	9,930.00	309,875.64	319,805.64
15RYLMN0004	0.00	2,315.00	0.00	0.00	2,315.00	5,718.75	8,033.75
15RYLMN0049	0.00	5,433.75	0.00	0.00	5,433.75	0.00	5,433.75
15RYLMN0075	0.00	0.00	20,000.00	0.00	20,000.00	49,955.00	69,955.00
15RYLMN0078	0.00	0.00	0.00	-16,528.75	-16,528.75	41,528.75	25,000.00
15RYLMN0079	25,000.00	13,580.10	0.00	0.00	38,580.10	119,476.50	158,056.60
15RYLMN0098	20,000.00	0.00	35,000.00	0.00	55,000.00	0.00	55,000.00
15RYLMN0106	0.00	2,610.00	0.00	0.00	2,610.00	34,390.00	37,000.00
15RYLMN0109	0.00	400.00	1,250,000.00	0.00	1,250,400.00	247,412.50	1,497,812.50
15RYLMN0136	0.00	1,404.00	0.00	0.00	1,404.00	68,842.40	70,246.40
15RYLMN0167	0.00	2,950.00	0.00	0.00	2,950.00	4,510.00	7,460.00
15RYLMN0171	0.00	3,175.00	0.00	0.00	3,175.00	13,550.00	16,725.00
15RYLMN0177	0.00	720.00	0.00	0.00	720.00	1,200.00	1,920.00
16RYLMN0095	0.00	437.50	0.00	0.00	437.50	3,992.50	4,430.00
16RYLMN0104	0.00	284.00	0.00	0.00	284.00	3,390.25	3,674.25
16RYLMN0130	0.00	1,500.00	0.00	0.00	1,500.00	1,541.50	3,041.50
16RYLMN0138	0.00	1,490.83	0.00	0.00	1,490.83	44,951.70	46,442.53
16RYLMN0139	500.00	0.00	0.00	0.00	500.00	21,495.00	21,995.00
16RYLMN0142	0.00	0.00	0.00	-13,011.54	-13,011.54	38,011.54	25,000.00
16RYLMN0145	40,000.00	0.00	30,000.00	0.00	70,000.00	10,755.25	80,755.25
16RYLMN0205	0.00	1,100.00	0.00	0.00	1,100.00	6,725.00	7,825.00
17RYLMN0004	9,500.00	0.00	0.00	0.00	9,500.00	4,345.00	13,845.00
17RYLMN0028	0.00	1.00	0.00	0.00	1.00	1,200.00	1,201.00
17RYLMN0030	0.00	0.00	0.00	0.00	0.00	18,100.00	18,100.00
17RYLMN0037	0.00	912.50	14,000.00	0.00	14,912.50	5,183.30	20,095.80
17RYLMN0038	0.00	0.00	0.00	0.00	26,000.00	41,861.00	67,861.00

17RYLMN0067	0.00	-3,787.40	0.00	-29,000.00	-32,787.40	57,787.40	25,000.00
17RYLMN0070	0.00	0.00	0.00	0.00	25,000.00	81,906.60	106,906.60
17RYLMN0071	0.00	1,500.00	0.00	0.00	1,500.00	3,917.50	5,417.50
17RYLMN0074	0.00	0.00	35,000.00	0.00	35,000.00	2,150.00	37,150.00
17RYLMN0093	0.00	400.00	0.00	0.00	400.00	3,850.00	4,250.00
17RYLMN0120	0.00	680.00	0.00	0.00	680.00	3,135.00	3,815.00
17RYLMN0130	0.00	0.00	783.21	0.00	783.21	6,600.00	7,383.21
17RYLMN0142	0.00	0.00	7,047.00	0.00	7,047.00	1,073.00	8,120.00
17RYLMN0150	0.00	9,015.00	0.00	0.00	13,815.00	6,875.00	20,690.00
17RYLMN0164	0.00	843.75	0.00	0.00	843.75	0.00	843.75
17RYLMN0188	0.00	535.83	12,000.00	0.00	31,035.83	3,622.92	34,658.75
17RYLMN0194	0.00	0.00	0.00	-33,040.00	-33,040.00	58,040.00	25,000.00
18RYLMN0011	0.00	300.00	0.00	0.00	300.00	50.21	350.21
18RYLMN0014	0.00	0.00	25,000.00	0.00	25,000.00	0.00	25,000.00
18RYLMN0030	0.00	1,618.75	0.00	0.00	1,618.75	0.00	1,618.75
18RYLMN0056	0.00	500.00	0.00	0.00	500.00	1,500.00	2,000.00
18RYLMN0057	0.00	0.00	0.00	-39,684.00	-39,684.00	64,684.00	25,000.00
18RYLMN0058	0.00	1,595.00	0.00	0.00	1,595.00	9,850.00	11,445.00
18RYLMN0059	0.00	1,432.50	0.00	0.00	1,432.50	9,523.48	10,955.98
18RYLMN0063	0.00	0.00	0.00	0.00	0.00	3,600.00	3,600.00
18RYLMN0068	0.00	5,353.73	0.00	0.00	5,353.73	186,385.75	191,739.48
18RYLMN0079	0.00	0.00	0.00	0.00	9,000.00	28,150.00	37,150.00
18RYLMN0109	0.00	0.00	5,000.00	0.00	5,000.00	98.35	5,098.35
19RYLMN0027	0.00	300.00	15,600.00	0.00	15,900.00	36,750.00	52,650.00
19RYLMN0033	0.00	0.00	4,000.00	0.00	7,250.00	0.00	7,250.00
19RYLMN0049	0.00	0.00	0.00	0.00	11,500.00	4,500.00	16,000.00
19RYLMN0062	0.00	900.00	0.00	0.00	900.00	0.00	900.00
19RYLMN0068	0.00	0.00	11,078.36	0.00	14,213.36	375.00	14,588.36
19RYLMN0084	0.00	1,100.00	0.00	0.00	1,100.00	0.00	1,100.00
19RYLMN0087	0.00	27.50	0.00	0.00	27.50	0.00	27.50
19RYLMN0115	0.00	1,575.00	0.00	0.00	1,575.00	0.00	1,575.00
19RYLMN0120	0.00	0.00	9,000.00	0.00	9,000.00	0.00	9,000.00
19RYLMN0126	0.00	3,787.40	0.00	0.00	3,787.40	0.00	3,787.40
20RYLMN0006	0.00	1,650.00	0.00	0.00	1,650.00	0.00	1,650.00
20RYLMN0022	0.00	25.00	0.00	0.00	25.00	0.00	25.00
20RYLMN0031	0.00	1,250.00	0.00	0.00	1,250.00	0.00	1,250.00
Total 01/06/2019 - 31/08/2019	**470,453.23**	**107,026.33**	**1,823,508.57**	**-1,079,133.73**	**1,321,854.40**		
Total						**9,556,547.19**	**10,878,401.59**

Personal Injury Payments 01/6/2019-31/08/2019							Appendix 2
Case Reference	Costs £	Defence Fee £	Claims £	WRP reimbursement £	Total £	Previous Write Offs £	Cumulative £
16RYLPI0031	0.00	255.00	0.00	0.00	255.00	730.00	985.00
18RYLPI0036	0.00	-440.00	0.00	0.00	-440.00	3,680.50	3,240.50
15RYLPI0047	0.00	1,500.00	16,259.80	0.00	17,759.80	9,098.00	26,857.80
19RYLPI0032	1,125.00	0.00	1,000.00	0.00	2,125.00	0.00	2,125.00
16RYLPI0004	0.00	920.00	0.00	0.00	920.00	205.00	1,125.00
17RYLPI0018	0.00	2,596.00	0.00	0.00	2,596.00	7,886.25	10,482.25
18RYLPI0017	970.83	310.00	1,000.00	0.00	2,280.83	0.00	2,280.83
18RYLPI0033	1,160.00	650.00	1,200.00	0.00	3,010.00	0.00	3,010.00
19RYLPI0023	1,125.00	0.00	1,000.00	0.00	2,125.00	0.00	2,125.00
19RYLPI0024	0.00	757.10	0.00	0.00	757.10	2,125.00	2,882.10
19RYLPI0029	1,125.00	0.00	1,000.00	0.00	2,125.00	0.00	2,125.00
20RYLPI0001	1,155.00	0.00	1,000.00	0.00	2,155.00	0.00	2,155.00
17RYLPI0003	8,258.33	0.00	6,000.00	0.00	14,258.33	562.50	14,820.83
18RYLPI0003	3,030.00	525.00	2,000.00	0.00	5,555.00	300.00	5,855.00
19RYLPI0014	0.00	750.00	0.00	0.00	750.00	5,760.00	6,510.00
19RYLPI0031	1,475.00	250.00	3,000.00	0.00	4,725.00	0.00	4,725.00
Total 01/06/2019 - 31/08/2019	**19,424.16**	**8,073.10**	**33,459.80**	0.00	**60,957.06**		
Total						**30,347.25**	**91,304.31**

Permanent Injury Benefit 01/06/2019 - 31/08/2019			Appendix 3
Laspar Number	In period Payments £	Previous Write-Offs £	Cumulative £
01RRSPI0020	3,375	189,387	192,762
02RVEPI0001	1,607	42,543	44,150
02RVEPI0003	2,541	137,630	140,170
02RVEPI0004	1,736	94,464	96,200
03RRSPI0020	11,786	681,679	693,466
03RVEPI0028	3,185	215,745	218,930
04RRSPI0009	3,457	180,918	184,375
04RRSPI0024	2,877	118,405	121,282
05RRSPI0020	1,371	59,218	60,589
05RRSPI0021	3,007	147,417	150,424
05RVEPI0033	4,664	225,046	229,709
05RVEPI0034	1,329	66,628	67,957
08RVEPI0009	3,159	143,403	146,561
10RYLPI0070	1,784	81,706	83,490
11RYLPI0065	5,117	170,189	175,306
12RYLPI0059	1,765	48,010	49,775
13RYLPI0020	937	24,465	25,402
13RYLPI0050	3,069	97,938	101,007
98RVEPI0005	100	5,584	5,684
19RYLPI0022	- 18,094	190,641	172,547
Total 01/06/2019 - 31/08/2019	**38,771**		
Total		**2,921,016**	**2,959,787**

Other Payments 01/06/2019 - 31/08/2019 **Appendix 4**

Case Reference	Nature of Loss	Details	Amount £
20RYLEG0013	Ex-Gratia	Damage to Property	300.00
20RYLEG0031	Ex-Gratia	Damage to Clothing	50.00
20RYLEG0053	Ex-Gratia	Loss of Money	400.00
20RYLEG0054	Ex-Gratia	Loss of Money	70.00
20RYLEG0014	Ex-Gratia	Retirement Gratuity	346.50
20RYLEG0015	Ex-Gratia	Retirement Gratuity	237.60
20RYLEG0016	Ex-Gratia	Retirement Gratuity	376.20
20RYLEG0017	Ex-Gratia	Retirement Gratuity	356.40
20RYLEG0018	Ex-Gratia	Retirement Gratuity	333.20
20RYLEG0019	Ex-Gratia	Retirement Gratuity	382.20
20RYLEG0020	Ex-Gratia	Retirement Gratuity	326.20
20RYLEG0021	Ex-Gratia	Retirement Gratuity	215.60
20RYLEG0022	Ex-Gratia	Retirement Gratuity	320.00
20RYLEG0023	Ex-Gratia	Retirement Gratuity	405.90
20RYLEG0024	Ex-Gratia	Retirement Gratuity	376.20
20RYLEG0025	Ex-Gratia	Retirement Gratuity	264.60
20RYLEG0026	Ex-Gratia	Retirement Gratuity	254.80
20RYLEG0027	Ex-Gratia	Retirement Gratuity	196.50
20RYLEG0028	Ex-Gratia	Retirement Gratuity	356.40
20RYLEG0029	Ex-Gratia	Retirement Gratuity	215.60
20RYLEG0030	Ex-Gratia	Retirement Gratuity	352.80
20RYLEG0032	Ex-Gratia	Retirement Gratuity	351.00
20RYLEG0033	Ex-Gratia	Retirement Gratuity	376.20
20RYLEG0034	Ex-Gratia	Retirement Gratuity	392.00
20RYLEG0035	Ex-Gratia	Retirement Gratuity	312.00
20RYLEG0036	Ex-Gratia	Retirement Gratuity	380.25
20RYLEG0037	Ex-Gratia	Retirement Gratuity	294.00
20RYLEG0038	Ex-Gratia	Retirement Gratuity	392.00
20RYLEG0039	Ex-Gratia	Retirement Gratuity	409.50
20RYLEG0040	Ex-Gratia	Retirement Gratuity	260.00
20RYLEG0041	Ex-Gratia	Retirement Gratuity	352.80
20RYLEG0042	Ex-Gratia	Retirement Gratuity	372.40
20RYLEG0043	Ex-Gratia	Retirement Gratuity	352.80

20RYLEG0044	Ex-Gratia	Retirement Gratuity	196.00
20RYLEG0045	Ex-Gratia	Retirement Gratuity	362.60
20RYLEG0046	Ex-Gratia	Retirement Gratuity	250.00
20RYLEG0047	Ex-Gratia	Retirement Gratuity	313.60
20RYLEG0048	Ex-Gratia	Retirement Gratuity	421.40
20RYLEG0049	Ex-Gratia	Retirement Gratuity	352.80
20RYLEG0050	Ex-Gratia	Retirement Gratuity	205.80
20RYLEG0051	Ex-Gratia	Retirement Gratuity	326.70
20RYLEG0052	Ex-Gratia	Retirement Gratuity	267.30
20RYLEG0056	Ex-Gratia	Retirement Gratuity	188.10
20RYLEG0057	Ex-Gratia	Retirement Gratuity	230.00
20RYLEG0058	Ex-Gratia	Retirement Gratuity	425.70
20RYLEG0059	Ex-Gratia	Retirement Gratuity	364.95
20RYLEG0060	Ex-Gratia	Retirement Gratuity	9.80
20RYLEG0061	Ex-Gratia	Retirement Gratuity	316.80
20RYLEG0062	Ex-Gratia	Retirement Gratuity	267.30
20RYLEG0063	Ex-Gratia	Retirement Gratuity	346.50
20RYLEG0064	Ex-Gratia	Retirement Gratuity	340.00
20RYLFP0001	Fruitless Payments	GP Out of Hours Tax & NI Liabilities (IR35 legislation)	165,128.78
20RYLBD0001	Bad Debt Write-off	Bad Debt Write-off	2,800.00
Total 01/06/2019 - 31/08/2019			**183,495.78**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.9** **28 October 2019**

Audit Committee Report
SGS EXTERNAL ISO14001 RECERTIFICATION AUDIT REPORT

Executive Lead: Chief Operating Officer
Authors: Dave Williams & Russell Hoare
Contact Details for further information: David.williams6@wales.nhs.uk, ext 28351 Russell.Hoare@wales.nhs.uk, ext 28688

Purpose of the Audit Committee Report
The Health Board had its ISO14001 recertification audit in June 2019, the findings of which are included in the CTMUHB SGS External ISO14001 Recertification Audit Report attached as Appendix 1, with an overview of the report findings provided below.

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 2019-2022, 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 the above objectives, but specifically on: • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance.

Supporting evidence	SGS External ISO14001 Recertification Audit Report

Engagement – Who has been involved in this work?
The ISO14001 Team, the Environmental Management Steering Group, and specific staff that manage a service that impacts on the environment within the Health Board.

Audit Committee Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Audit Committee is asked to: • **NOTE** the findings of the report						

Summarise the Impact of the Audit Committee Report	
Equality and diversity	Conveys how the Health Board is ensuring that the services provided are accessible and sustainable into the future.
Legal implications	Conveys how the Health Board is managing its impact on the environment in accordance with the international standard ISO14001, which is a requirement by Welsh Government.
Population Health	Conveys how the Health Board is managing its impact on the environment, ultimately improving population health.
Quality, Safety & Patient Experience	Conveys how the Health Board is managing its impact on the environment, improving patient experience.
Resources	Conveys how the Health Board is managing its impact on the environment by using resources efficiently and effectively.
Risks and Assurance	Provides assurance to both stakeholders and Welsh Government that the Health Board is managing its impact on the environment and associated risks effectively.
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.
Workforce	Conveys how the Health Board staff are working together to minimise their impact on the environment.
Freedom of information status	Open

SGS EXTERNAL ISO14001 RECERTIFICATION AUDIT REPORT

1. SITUATION / PURPOSE OF REPORT

The Health Board had its ISO14001 recertification audit in June 2019, the findings of which are included in the CTMUHB SGS External ISO14001 Recertification Audit Report attached as Appendix 1, with an overview of the report findings provided below.

2. BACKGROUND / INTRODUCTION

ISO14001: 2015 is the international standard that specifies requirements for an effective environmental management system (EMS). It is a requirement of Welsh Government that all Health Boards in Wales be accredited to ISO14001: 2015. As part of this accreditation the Health Board is audited by the external auditing body SGS on a three year recertification cycle, with surveillance audits every year. The Health Board had its ISO14001 recertification audit in June 2019.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Audit Result: Successful Recertification with 3 minor Non-Conformities (N/Cs).

Positive Observations:

- Capital Projects - The auditor met with Capital and the contractor Interserve and was complimentary about the planning process used and the incorporation of organisational policies (e.g. environmental, energy, waste policies) and sustainable construction practices (e.g. BREEAM) within capital schemes.
- Energy & Carbon - It is pleasing to note the year on year reduction in energy & carbon emissions and that opportunities are being taken through the Green Growth programme to further reduce energy consumption and review renewable energy opportunities. The recent appointment of another member to the Energy team to increase the effort in energy management is pleasing to note. CHPs and biomass boilers are still operational with Cwm Taf Morgannwg.
- Planned Maintenance - There was a high standard of compliance with regards to carrying out external service of equipment that is checked during the environmental audits. There was excellent retrieval of service records, excellent standard of housekeeping in the plant rooms.
- Legionella Risk Assessments & Asbestos Management Plans were in place and necessary actions being undertaken.
- Waste Management data recording and housekeeping of waste areas was very good.
- Travel initiatives were progressing well with lift share, electric vehicles and videoconferencing, acknowledging that this is a particularly difficult area to manage.
- The auditor commented how well the Facilities and Estates Directorates have worked together.

General Observations:

- Could promote the good work being done within Capital, Facilities and Estates more within the organisation.
- Interested to see how Bridgend will now be incorporated within procedures moving forward (e.g. maintenance records, energy, waste, transport etc.)

3 Minor Non-Conformities raised:

1. Management Review - The Agenda for management review has not been updated to the new mandatory requirements of ISO 14001:2015 in either the 1.1 EMS Manual or the 3.3 documented Procedure.

Regarding N/C No 1 the Facilities Governance & Compliance Manager will make sure that the next Management Review, due in March 2020, will have this information included.

2. Control of Contractors - There was no evidence of following the control of contractor's procedure consistently in terms of having the rules signed following a spot check undertaken by the auditor, picked two contractors. Also the control of contractors process does not fully function after 3.45pm as this is when site based staff leave and so any contractors coming onto site or completing their work after this time will not be able to complete the necessary paperwork (e.g. permits to work close out or signing in and out).

Regarding N/C No 2 the Operational Estates Manager has stated that the Contractor Policy goes out to contractors and Managers record receipt in tender. Operational Estates Manager will review the Control of Contractor's Policy document with Facilities Governance & Compliance Manager.

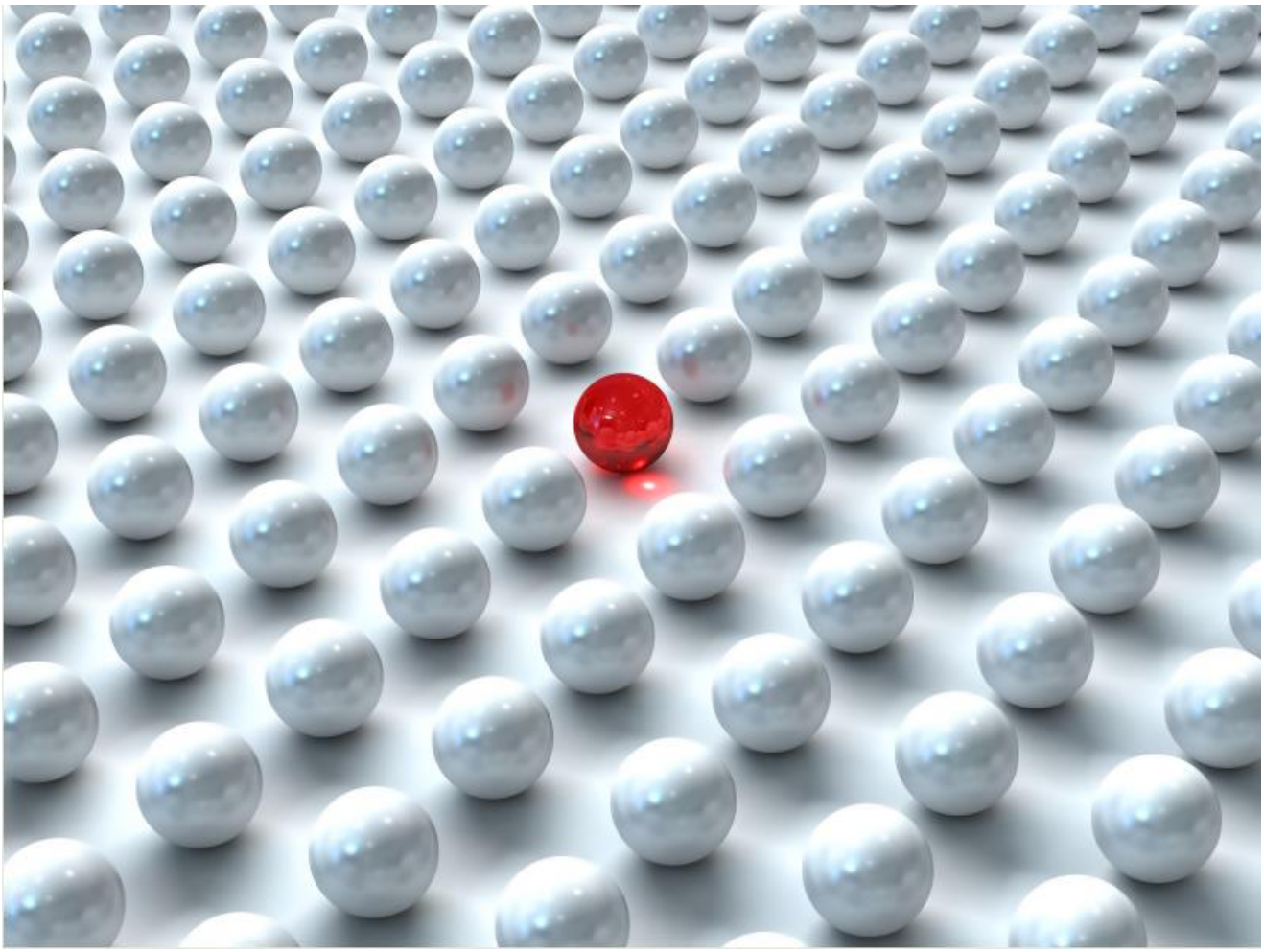
3. Planned Maintenance - The annual planned service for the boiler at Medical Records has been missed (last completed 30/01/18). In addition to this the asset register for the refrigeration units at the Mortuary in Royal Glamorgan did not include the volume of refrigerant F-gas and its carbon dioxide equivalents as required by the legislation. These are both compliance obligations in terms of mandatory planned maintenance & associated record keeping.

Regarding N/C No 3 the Operational Estates Manager stated that Mortuary air conditioning service comes under Estates remit. Facilities Compliance Team will work with relevant managers to develop a Master F-Gas Register by the next ISO audit.

4. RECOMMENDATION

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

- **NOTE** the findings of the report



Audit Report for: Cwm Taf Morgannwg University Health Board

Visit Number: 1 Recertification Audit

For training on this management system and for all your training needs, please visit the SGS Academy at www.sgs.co.uk/trainingbrochure

To subscribe to the SGS newsletter please visit www.sgs.co.uk/en-GB/Our-Company/E-Subscriptions.aspx

Management System Certification – Client Report

Organisation:	Cwm Taf Morgannwg University Health Board		
Address:	Prince Charles Hospital Mountain Ash Merthyr Tydfil CF47 9DT		
Site(s) audited:	Prince Charles Hospital, Royal Glamorgan Hospital, Linen Services, Kier Hardy Medical Centre Hirwuan Medical Centre, Ysybyty Cwm Rhondda, Ysbyty Cwm Cynon, Rhondda Mental Health Clinic, Aberdare Health Clinic, Dewi Sant, Ysbyty George Thomas, Ystrad Clinic, Treharris Primary Care, Aberdare Health Clinic, Carnegie Clinic, Llwyn-yr-eos Clinic, Pontypridd Health Centre, Tonteg Health Clinic, Ynysmuerig House, Central Production Unit, Hirwaun Medical Centre, Medical Records, Rhondda Mental Health Clinic, Maesycoed/Maritime Resource Centre (mental health)	Date(s) of audits(s):	29/04/2019-14/06/19
Visit Number:	1	Observer(s):	
Representative:	Russell Hoare	Additional member(s):	
Lead auditor:	Amanda Thorpe		
This report is confidential and distribution is limited to the audit team, audit attendees, client representative, the SGS office and may be subject to Accreditation Body, Certification Scheme owners or any other Regulatory Body sampling in line with our online Privacy Statement which can be accessed here			

This report is confidential and distribution is limited to the audit team, client representative and the SGS office.

System type:	Single

Standard	Accreditation Body	Scope of Certification
ISO 14001:2015	UKAS	The management of environmental aspects associated with the provision of healthcare and

		clinical services at the following sites: • Prince Charles Hospital • Royal Glamorgan Hospital • Community Hospitals, Health Centres & Clinics Rheoli agweddau amgylcheddol mewn perthynas â darparu gofal iechyd a gwasanaethau clinigol yn y safleoedd canlynol: • Ysbyty'r Tywysog Siarl • Ysbyty Brenhinol Morgannwg • Ysbytai cymunedol, canolfannau iechyd a clinigau

The objectives of this audit were to determine conformity of the management system, or parts of it with audit criteria and its:

- ability to ensure applicable statutory, regulatory and contractual requirements are met,
- effectiveness to ensure the client can reasonably expect to achieve specified objectives, and
- ability to identify as applicable areas for potential improvement.

Is the organisation management system meeting the stated objectives of the audit?		Yes
Have all unresolved findings from the previous audit been satisfactorily addressed?		Yes
Non-conformance Identified?	Major: 0	Minor: 3
Therefore the audit team recommends that, based on the results of this audit and the system's demonstrated state of development and maturity, management system certification be:		Continued

Changes	
Level of Integration?	N/A
Key/Significant Organisational changes? (e.g key personnel, client activities, management system)	No
Key/Significant System changes?	No

Sample reviewed

- The clinical sites in Bridgend have transferred to Cwm Taf in April 2019
- New addition to the name, Morgannwg reflecting the Bridgend clinical sites
- Major construction activities, one at Royal Glamorgan (15 bed McMillan palliative care facility) and one at Prince Charles for a refurbishment of the ground and first floor.
- New Manager, Dave Williams, Facilities Governance & Compliance Manager, joined in October 2018
- Confidential waste contractor has been changed.
- Legionella risk assessments are now being completed by another organisation, JD Water.
- Clinical waste collections from domestic properties had always been carried out by the local authorities (and charged the health board). This waste collection in RCT area was transferred to a Health Courier Service, who also manage the helpline call centre. The waste collection from domestic properties in Merthyr is managed by the local authority. (Bridgend clinical waste collections is managed by Stericycle).
- The Environmental Policy and SGS certificate may require to be in welsh.

Executive Summary

This was a recertification audit over a significant amount of time and covering a large number of sites. It was an excellent performance and Cwm Taf Morgannwg University Health Board is recommended for recertification. Only 3 minor NCRs were raised, reflecting an outstanding performance in a very detailed and comprehensive scrutiny of the environmental management system,

There were a large number of highlights, including:

- System: There is an efficient and effective management system managed centrally by a core team that is robust and reliant and capable of being extended to new departments (e.g. Dental) or new sites (e.g. Princess of Wales & Bridgend sites). The management system has strong foundations and reflects the needs and expectations of the Health Board itself.
- Organisation: The organisational arrangements, particularly the team and partnership working with Estates has led to quick implementation or various initiatives, including waste management practices, travel & transport provisions and cleaning standard operational procedures.
- People: There was significant engagement and support from all those interviewed during the audit

demonstrating that the EMS is clearly well embedded into all levels and areas of the business. A team approach was very evident and it was pleasing to note that the environmental awareness module is mandatory for all staff and that the same practices were consistently applied across all sites, big or small, clinical or non-clinical.

- Places: There is excellent management of the buildings across the portfolio of clinical and non-clinical sites. There was good repurposing of some older buildings and mothballing of those that were no longer in use. Newer buildings had modern energy saving technology and made use of natural lighting and ventilation.
- Grounds: There was an exceptionally high standard of management of the exterior of all the sites, regardless of size and opportunity. Sites were litter free and well maintained. Where practicable, there was evidence of best practice in terms of leaving some grass areas to be more wild, to encourage local wildflowers and orchids and there was proactive planting of trees. There was good use of courtyard space for gardens for patients.
- Interested Parties: There was excellent feedback from the Effluent Trade Officer of Dwr Cymru Welsh Water about the standard of effluent from both the Central Production Unit and the Central Laundry (Linen Services) that both discharge to the sewer. Where sites had a shared arrangement e.g. with GPs or Pharmacy, communal waste management arrangements were put in place by Cwm Taf to maximise the waste recycling regardless. Cwm Taf are working with Men Sheds and Keep Wales Tidy to expand the creation of gardens for patients and staff.
- Waste: There was excellent, strict adherence to operational controls for clinical waste, whilst at the same time, recycling considerable volumes of wastes across all sites. The recycling rate must be one of the highest in Wales NHS and the recent introduction of collecting food waste separately for anaerobic digestion is a proactive step in line with current Welsh Assembly thinking about stopping the use of macerators. There was excellent encouragement & adoption of optimum separation of wastes to maximise recycling & recovery and minimise landfill and incineration. Clear messaging, excellent reusability of bins and signs to ensure flexibility and multi-purpose use of bins and signs was noted throughout the large Cwm Taf campus. Furthermore, the design of the bins is meant to maximise the lifespan and usability (and end of life recyclability) of the bins in clinical environments with strict infection controls. The high recycling & recovery rates is outstanding for a healthcare campus and is a reflection of the domestic team as well as the EMS Team.
- Energy & Carbon: It is pleasing to note the year on year reduction in energy & carbon emissions and that opportunities are being taken through the Green Growth programme to further reduce energy consumption and review renewable energy opportunities. The recent appointment of another member to the Energy team to increase the effort in energy management is pleasing to note. CHPs and biomass boilers are still operational with Cwm Taf Morgannwg.
- Travel & Transport: It was noted that work is in progress to review the travel footprint. To reduce business mileage, Skype is being introduced and there was both car-sharing in action and a shuttle bus running between some of the sites. Electric Estates vans are in use in the Bridgend sites and it is likely that this will be rolled out to other sites within the Cwm Taff portfolio. There is robust data and liaison with the lease car company to ensure low carbon vehicles only are used.
- Planned Maintenance: There was a high standard of compliance with regards to carrying out those external service of equipment that is checked during the environmental audits. There was excellent retrieval of service records, excellent standard of housekeeping in the plant rooms.
- Catering: The CPU method of cooking in bulk and then quick-freezing means that there is minimal food waste (less than 3%) and it is in one location. The frozen meals are then ordered by each patient, each site, on the day. Only food destined for a patient is transported. This has also considerable reduced the volume of food waste. It has also allowed for greater choice for the patient and for the staff. The CPU has been in existence since 1988 (so just over 30 years) and it has been optimised in terms of efficient equipment, freezers and cold room and, processes in terms of recipes, nutrition, vegan &U vegetarian and food allergies & intolerances as well as volumes & appealing to patients. Relationships with local food suppliers was clear and this method has allowed Cwm Taf Morgannwg to be resilient to changes, whether it be the increase in the clinical campus with the Bridgend sites now joining but also for emergency preparedness to ensure sufficient food available for any issues associated with Brexit or any other national Just in time ordering of food by patients has resulted in a reduction in food waste and there is continued focus on the use of single use plastic and opportunities to make changes to further reduce.
- Dental: The Dental Department transferred to Cwm Taf on 01/04/19 and the transition has been efficient and organised with regards to waste management and management of compliance obligations and records.

In summary, for a large number of the significant environmental aspects, exemplary implementation of best practice was observed. Cwm Taf is meetings its compliance obligations, demonstrating continual improvement, achieving challenging energy, carbon and waste recycling targets.

The outstanding quality of the grounds & landscaping demonstrate the positive contribution to local visual landscape and biodiversity that a hospital and clinic campus can contribute, that goes beyond compliance and is in keeping with other health and well-being initiatives related to wellbeing for staff as well as for patients and visitors. There are clear ecological practical actions being implemented with regards to leaving some areas in a more natural environmental state with excellent planting to enable there to be flowers open and available for pollinators

Finally, in terms of leadership, governance and organisational arrangements, the current provisions for the Environmental Steering Group and ISO 14001 Team are clearly working very effectively and successfully with clear leadership and inter departmental support demonstrated throughout this audit. The mandatory e-learning module for environment, waste and energy has been efficiently rolled out, with excellent uptake by all staff. This addresses the challenge of raising awareness across multiple sites, across an exceptionally large and diverse workforce and provides verifiable evidence of completion of the environmental module by staff. Strong leadership was demonstrated through the organisation, both at a department & site level, and especially at the Estates & Facilities Directorate level.

It was an outstanding performance in the recertification audit.

Observations and Improvement Opportunities

Consideration could be given to the following:

Policy

1. Neither the Policy nor the SGS ISO 14001 certificate are available at www.cwmtaf.wales This is not in keeping with best practice that encourages making the Environmental Policy publicly available but also people might not realise that Cwm Taf has an environmental policy and ISO 14001 as it is not at all mentioned within the website. This could be perceived as a missed opportunity.

2. It is noted that the Environmental Policy is due to a routine review in October 2019 which will take into account the requirement for multiple changes including the need for the policy to be bilingual, reflect the organisation name change and the addition to scope of the Bridgend sites, that this review may take longer than usual, particularly as all other Cwm Taf policies might also be needing to be updated.

3. Consider displaying the Environmental Policy in a different colour paper on the official notice boards to make it stand out against a back drop of other Policies, also printed on white paper.

Interested parties

4. Local authority, Dwr Cymru Welsh Water & local community not currently included in register (with respect to needs of noise free, litter free, biodiversity, traffic, travel plans & congestion etc).

5. It could be considered useful to include the needs of WAG that Cwm Taf implement the Wellbeing of Future Generations Act and the 3% carbon reduction.

6. Might be useful to include the expectations of employees with regards to clear waste segregation policies & arrangements and an opportunity to recycle.

7. Might be useful to reference shared 'tenants' at some of the clinical sites, if relevant

Aspects

8. Potential release of legionella to air not included within the aspects register but was manged as a significant aspect.
9. Collection of clinical waste from domestic properties could be usefully added to the aspects register.
10. Positive introduction of hospital gardens could be usefully referenced within the aspects register as useful biodiversity & visual impact benefits.
11. Continue to review aspect significance scoring process (slight tendency to focus on post control scoring than pre-control/pre-legislation but the same outcome is noted, in terms of significance priority rating).
12. The Aspects procedure could usefully reference how Cwm Taf addresses the life cycle perspective.

Compliance Obligations

13. Consider reviewing the following compliance obligations for applicability:
    - F-gas Regulations 2018
    - The Hazardous Waste (Miscellaneous Amendments) (Wales) Regulations 2018
    - The Conservation of Habitats and Species Regulations 2017
    - The Waste Electrical and Electronic Equipment (Amendment) Regulations 2018
    - Waste Batteries & Accumulators (Amendment Regulations) 2015
    - The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018 (specifically for Ionising Radiation)
    - The Ionising Radiation (Basic Safety Standards) (Miscellaneous Provisions) Regulations 2018 and The Justification of Practices Involving Ionising Radiation (Amendment) Regulations 2018
    - The Gas Safety (Installation and Use) (Amendment) Regulations 2018 (for the accommodation rented out to staff)
    - EH40/2005 Workplace exposure limits Update 2018.
    - Clean Neighbourhoods and Environment Act 2005
    - Mercury Regulations 2017

EMS Records

14. Consider giving guidance of how long the different EMS records are to be retained (Procedure 1.6a).

Internal Auditing

15. Adding capital programme, contractor management, procurement, and cross reference to relevant health and safety audits for asbestos and Legionella/Pseudomonas management to the audit schedule

Continual Improvement

16. Provide a detailed update on Green Growth energy projects & electric car charging points at the next SGS audit.

Contractor Control

17. Permit to work not always closed out e.g. 18 & 19 September 2018 sheets as after 3.30pm, there are no Estates staff to carry out this process. This issue needs to be resolved.
18. Plans to include a separate contractors' procedure for non-Estate Managed contractors. Please provide an update at the next SGS audit.

Grounds Maintenance

19. Consider having a drain cover mat permanently over the drain in the petrol storage room within the

Grounds Maintenance Area at Royal Glamorgan Hospital so that in the event of a spill or leak, the contents do not enter the drain.

20. Review whether there is an opportunity to have a control procedure to document the current grounds operational controls in terms of the cutting regime and wildlife sowing and use of pesticides, rodenticides & herbicides etc.

Chemical Management & COSHH

21. Annotate and update the site COSHH register to reflect that the SDS for Hospic chlorine tablets but the chemical on sites was Simple Corchlor (e.g. at Trealaw & Ystrad).

22. The COSHH folder was not available at Treharris or at St Johns. This was corrected following the site visits but mechanisms (and cross checks) must be in place to consistently ensure that safety data information for all the chemicals used by the domestics are at the point of use (so storage area of chemicals) and accessible by staff at the clinics.

Energy & Carbon Management

23. Provide a detailed update on Green Growth energy projects & roll out of electric car charging points & electric vehicles within the Cwm Taff Morgannwg fleet.

24. The All Wales Electricity Contract is based on a Renewable Energy Guarantee of origin (REGO) but the 2018/19 British Gas certificate to confirm this is not available until August 2019. Please provide confirmation at the next SGS audit.

25. Provide an update, at the next SGS audit, with regards to whether the energy performance of buildings (e.g. with regards to the need to provide a DEC certificate) applies to the accommodation rented to medical personnel.

26. Consider including the actual year on year energy & water performance data within the annual management review.

Land & Biodiversity Management

27. If not done so already, please formally notify the local authority about the presence of ash die back at the Royal Glamorgan Hospital.

28. Please add the presence of contagious plant disease, including ash die back to the aspects register as there may be formal notification processes as well as tree surgery and removal control methods needed.

F-gas Management

29. There are some departments who have individual responsibility for their F-gas management (e.g. Mortuary in Royal Glamorgan and the Central Production Unit) and retain the relevant documentation. Some minor issues were found with this documentation, that was corrected during the audit. Consideration could be given to including a formal audit or quick check within the EMS of this documentation.

30. Where F-gas compliance records are kept by other departments, consider whether it would be prudent to retain copies also within the EMS and the Estates documentation (for resilience and continuity purposes).

Asbestos Management

31. Asbestos Management Plan version 4 (February 2018) is due for a review. Provide an update at the next SGS audit.

32. The Inspection programme for Merthyr block at Price Charles Hospital is slightly overdue (due May 2019), all others completed on time.

Hirwaun Medical Centre

33. There were no actual recycling wheelie bins in the external recycling store. The arrangements for recycling could be further reviewed to understand the situation at this shared site.

Central Laundry/Linen Services

34. Consider colour coding the drains at East Glamorgan Laundry to show which are surface and which are foul sewer. The COSHH and safety data folder would benefit from being alphabetically indexed.

35. The water from the steam boiler at the Central Laundry falls onto natural ground. Water from the condensate from the steam boiler also falls onto the natural ground. This is poor practice and could lead to localised flooding or the water could come into contact with materials stored on the ground (in this case boiler salt and leftover construction debris). Work was in progress to install a new connection pipe to the drain during the audit.

36. Construction type waste had been left on natural ground behind the boiler house at the Central Laundry. This waste was removed during this audit. Consider introducing a schedule of inspections for some key areas such as the Linen Services Central Laundry.

37. An excess of pallets (mostly broken) was noted during the audit. Arrangements were in place to remove the pallets. Ensure there is no further large build-up of pallets, if practicable.

38. There were no recent records of the volume of effluent discharges at the Central Laundry to confirm that it is compliant with the DCWW discharge consent albeit conversations with DCWW Trade Effluent Officer during the audit indicated that there were no concerns from DCWW. Investigate further whether there should be volume monitoring in place and provide an update at the next audit.

39. Provide an update at the next SGS audit, to confirm what happens with obsolete linen.

40. The drainage consent from Dwr Cymru Welsh Water for the Central Laundry (TE453 on 02/11/92) is in the name of Mid Glamorgan Health Authority). It could be useful to update the Consent into Cwm Taf Morgannwg's name.

Mortuary at Royal Glamorgan

41. The asset register for the refrigeration units at the Mortuary in Royal Glamorgan did not include the volume of refrigerant F-gas and its carbon dioxide equivalents. Consider introducing an annual check of those departments who self-manage the F-gas compliance to ensure all mandatory details are included.

Ysbyty Cwm Cynon

42. Some expensive redundant plant equipment was noted. It was not known whether this could be removed and reused by another NHS facility. Is there an opportunity to review the possible release of large items of redundant & expensive plant equipment that is in working order but not required for reuse by Cwm Taf.

43. It was not known when the woodchip biomass boiler operations were last reviewed to understand if there are any opportunities to improve the performance. Please provide an update at the next SGS audit.

44. The courtyard gardens are to get a 'make over' and upgrade. Please provide an update at the next SGS audit.

Opening & Closing Meeting Attendees			
Name	**Position**	**Opening Meeting**	**Closing Meeting**
David Williams	Facilities Governance & Compliance Manager	Yes	Yes
Wayne Burnett	Waste & Transport Manager	Yes	Yes
Richard Edwards	Compliance manager	Yes	Yes
Craig Edwards	Waste & Transport Officer	Yes	Yes
Gary Humphrey	Energy Manager		Yes
James Edwards	Energy Support Officer		Yes
Individual Opening & Closing meeting with Russel Hoare	Acting Assistant Director Facilities (ISO 14001:15 lead)	Yes	Yes

Any other comments
There will be an extension to scope audit to include the Bridgend sites which may take place prior to the next surveillance v2 audit in 2020.

Notes to the client and what happens next

This audit report will be processed and an invoice will be dispatched to you.

Disclaimer – the audit is based on a sampling process of the available information. Audit recommendations where issuance of a certificate is required are subject to an independent review prior to a final decision concerning the awarding of the certificate.

Non-conformance - what you must do

Corrective Actions to address identified minor non conformities including a root cause analysis, which shall be documented on an action plan. Where actions are deemed to be satisfactory , they will be followed up at the next scheduled visit.

Failure to address a major non-conformance within the timescales will result in certification being withheld or suspended.

Failure to address a minor non-conformance within the timescale can result in escalation of the non-conformance to major at the subsequent visit.

For major non-conformance - Corrective action (including a cause analysis) to take place immediately. SGS will perform an appropriate follow up visit within 90 days confirming that actions have been effective. The certification decision shall be made based on the outcome of the follow up visit.	
The client must notify SGS of the root cause & proposed actions within 30 days of this visit	☐
The client must send SGS records with supporting evidence	☐
Major non-conformance follow-up to take place on:	

For minor non-conformance - Corrective Actions to address identified minor non-conformities including a cause analysis shall be documented on an action plan. Where actions are deemed to be satisfactory, they will be followed up at the next scheduled visit.	
The client shall send SGS its action plan within 90 days to determine if the proposed actions will be satisfactory.	☐
The client has reviewed the non-conformance to the satisfaction of the auditor and defined an appropriate action plan. Note:- Initial, Re-certification and Extension audits – recommendation for certification cannot be made unless this check box is completed. For re-certification audits the time scales indicated may need to be reduced in order to ensure re-certification prior to expiry of current certification.	☒
The client has taken appropriate immediate action in response to non-conformance(s) required.	☐

Nonconformity	N° 1 of 3	Minor	
Standard	ISO 14001:2015	Clause	9.3
Nonconformity Statement	The following were not included in the annual management review for 2019 as required by ISO 14001:2015: changes in: 1) external and internal issues that are relevant to the environmental management system; 2) the needs and expectations of interested parties, including compliance obligations; 4) risks and opportunities; c) the extent to which environmental objectives have been achieved; e) adequacy of resources; f) relevant communication(s) from interested parties (including complaints) The Agenda for management review has not been updated to the new mandatory requirements of ISO 14001:2015 in either the 1.1 EMS Manual or the 3.3 documented Procedure The Minutes of the management review for 2019 were not available for the audit.		
Evidence	03 March 2019 Management review report Absence of management review minutes		
Actions Proposed	Produce minutes of the Management review Update the agenda for the annual management review and ensure the next annual management review includes the formal ISO 14001:2015 mandatory requirements.		

Nonconformity	N° 2 of 3	Minor	
Standard	ISO 14001:2015	Clause	8.1
Nonconformity Statement	Control of Contractors: 1) There was no evidence of following the control of contractor's procedure consistently in terms of having the rules signed. In a small sample, the following contractors who have been on Royal Glamorgan in the past 12 months had not participated in the control of contractor Rules process • Power Electric • Lanes for Drains 2) The control of contractors process does not fully function after 3.45pm as this is when site based staff leave and so any contractors coming onto site or completing their work after this time will not be able to complete the necessary paperwork e.g. permits to work close out or signing in and out.		
Evidence	Control of Contractors Procedure Absence of completion by Power Electric & Lanes for Drains		
Actions Proposed	Review the list of contractors and cross reference against the received 'Completed Slips' for the contractors used by Estates Complete any necessary environmental rules communication & training for contractors who have been missed. Review the arrangements for control of contractors post 3.45pm.		

Nonconformity	N° 3 of 3	Minor	
Standard	ISO 14001:2015	Clause	8.1
Nonconformity Statement	**Planned Maintenance** The annual planned service for the boiler at Medical Records has been missed (last completed 30/01/18). The asset register for the refrigeration units at the Mortuary in Royal Glamorgan did not include the volume of refrigerant F-gas and its carbon dioxide equivalents as required by the legislation. These are both compliance obligations in terms of mandatory planned maintenance & associated record keeping.		
Evidence	Asset Register for Mortuary, Royal Glamorgan 2019 Boiler at Medical Records Boiler service records (CST, 30/01/18 & absence of boiler records for 2019).		
Actions Proposed	Update the asset register accordingly and confirm frequency of leak testing that is required as per volume of refrigerant gas held in the units. Review why the boiler service at Medical Records was missed and what checks could be put in place to ensure it is not missed again. Carry out necessary annual service of boiler at Medical Records		

Audit Plan – Next Visit

Site(s) to be visited:	Prince Charles Hospital, Royal Glamorgan Hospital & community hospitals & clinics as per plan below		
Audit Language:	English	Visit Number:	2
Visit Due by Date:	26/07/2020	Provisional Planned Visit Date(s):	Tbc (10.5 days)
Lead Auditor:	Amanda Thorpe	Team Member(s):	

Audit objectives: To confirm that the management system has been established and implemented in accordance with the requirements of the audit standard.

Date	Time	Auditor	Site / Area / Department / Process / Function	Contact
tbc	09:00	AT	PCH Opening meeting Update & any Changes within organisation Confirmation of scope	Dave Williams, Wayne Burnett, Richard Edwards
Day 1	09:30	AT	follow up of findings from previous SGS visit & any environmental complaints or incidents or compliance breaches. Confirmation of audit plan including site visits & capital project visits	
	10:30	AT	Context, Issues, risks & opportunities Aspects & Impacts	
	11:30	AT	Compliance Obligations & Confirmation	
	13:00	AT	Lunch	
	13:30	AT	Continual Improvement, Objectives & Targets, Environmental performance monitoring	
	15:00	AT	Internal audits, Corrective action & Management review, use of SGS logo	
	16:30	AT	End of Day Review	
		AT		
tbc	08:45	AT	Arrive at PCH	

Day 2	09:00	AT	Site Tour: Plant Rooms, waste areas, carparks and sample of wards & areas of the hospital site	
	11:00	AT	Energy & Carbon Management	
	12:30	AT	Lunch	
	13:00	AT	Waste Management (including records)	
	14:30	AT	Transport & Fleet Management	
	16:30	AT	End of Day Review	
tbc	09:00	AT	Meet at PCH Capital planning: review projects Site visit site to review control of contractors, operational controls & performance Environmental issues associated with construction & refurbishment	
Day 3	13:00	AT	Lunch	
	14.00	AT	Site visit: **Princess of Wales**: Operational controls, environmental performance, monitoring, site tour Waste management arrangements Planned maintenance arrangements & records Emergency preparedness at POW Plant rooms	
	16:30	AT	End of Day Review	
tbc	09:00	AT	Arrive at **Glanrhyd**	
Day 4	09:15	AT	Site Tour: Plant Rooms, waste areas, carparks and sample of wards & areas of the hospital site	
	11:00	AT	Grounds Management	
	12:30	AT	Lunch & Travel to **Maesteg**	
	13:30	AT	Site Tour: Plant Rooms, waste areas, carparks and sample of wards & areas of the hospital site	
	15:00	AT	Control of Contractors at Bridgend sites Maintenance/Estates Local Procedures	
	16:30	AT	End of Day Review	
Tbc Day 5	09.00-17 00	AT	Off-site Reporting	

tbc	09:00	AT	At RGH	
Day 6	09.15	AT	Central Production Unit	
	11:30	AT	Catering at RGH	
	12:30	AT	Lunch	
	13:00	AT	Visits to Special Departments: Pharmacy Radiopharmacy Mortuary Physiotherapy	
	16:30	AT	End of Day Review	
tbc	09:00	AT	Meet at RGH	
Day 7	09:30	AT	Central Laundry:/Linen Services Operational controls, environmental performance, energy & water monitoring	
	11.00	AT	YCC Site Visit	
	12:30	AT	Lunch	
	13:30	AT	YCR Site Visit	
	16:30	AT	End of Day Review	
tbc	09:00	AT	Meet at PCH	
Day 8	09:30	AT	Asbestos Management	
	10.30	AT	IT – Servers & IT Equipment & Digitalisation Update & IT Initiatives to reduce environmental impacts	
	11:30	AT	Legionella Management	
	12:30	AT	Lunch	
	13:00	AT	Oil & Fuel Management	
	14:00	AT	COSHH & Cleaning Chemicals used	
	15:00	AT	Emergency Preparedness	
	16:30	AT	End of Day Review	
tbc	09:00	AT	Meet at RGH	
Day 9	09:30	AT	Site Visit: Dewi Sant	
	11.00	AT	Site Visit: Pontypridd Health Clinic: Dental Department	

	12:30	AT	Lunch & Travel	
	13:30	AT	Interested Parties Internal & External Communications Environmental Complaints	
	14:30	AT	Awareness, Competency, Training	
	15:30	AT	Management of Contractors – Estates & Facilities & IT contractors	
	16:30	AT	End of Day Review	
tbc	09:00-17.00	AT	Off site reporting	
Day 10				
tbc	09.00	AT	Arrive at PCH or RGH (to be confirmed)	
Day 10.5	09.30	AT	Interview with senior leadership representative	
	10.15	AT	Preparations and review for next SGS annual audit with the EMS Team – selection of sites to be visited	
	11.00	AT	Closing meeting	
	12.00-13.00	AT	Finalise SGS audit reports & issue	

Notes to Client:

- Times are approximate and will be confirmed at the opening meeting prior to commencement of the audit.
- SGS auditors reserve the right to change or add to the elements listed before or during the audit depending on the results of on-site investigation.
- A private place for preparation, review and conferencing is requested for the auditor's use.
- Please provide a light working lunch on-site each audit day.
- Your contract with SGS is an integral part of this audit plan and details confidentiality arrangements, audit scope, information on follow up activities and any special reporting requirements.

1 - See page 2 for the management system scope of certification

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.10** **28 OCTOBER 2019**

Audit Committee Report
STANDARDS OF BEHAVIOUR POLICY DECLARATIONS OF INTEREST / REGISTER OF GIFTS AND HOSPITALITY 2018-2019

Executive Lead: Director of Governance / Board Secretary
Author: Kathrine Davies, Interim Corporate Governance Support
Contact Details for further information: Georgina Galletly – 01443 744818 or email Georgina.galletly2@wales.nhs.uk

Purpose of the Audit Committee Report
To provide the Audit Committee with information following receipt of the annual declarations of interest from Health Board staff and the Register of Gifts and Hospitality for 2018-19.

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 2019-2022 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 mainly on providing strong governance & assurance.
Supporting evidence	• Standards of Behaviour Policy • Standing Orders
Engagement – Who has been involved in this work?	
Board Members; All Senior Staff; Consultants in line with the requirements of the Standards and all staff at Band 8 or above.	
Audit Committee Resolution to:	

APPROVE		ENDORSE		DISCUSS	√	NOTE	√
Recommendation	The Audit Committee is asked to: • **RECEIVE** and **NOTE** the report and supporting appendices in relation to the Health Board's Standards of Behaviour Policy; and • **NOTE** the ongoing actions being taken to improve compliance.						
Summarise the Impact of the Audit Committee Report							
Equality and diversity	No specific impact identified all relevant staff required to complete						
Legal implications	No specific impact						
Population Health	No impact identified						
Quality, Safety & Patient Experience	Not related to patient care directly						
Resources	Online (intranet – SharePoint) requirement staff to access personally to complete.						
Risks and Assurance	Failure to declare relevant and material interests could place Health Board staff in a position where a conflict of interest occurs. This could lead to circumstances that would impact badly on the reputation of the Health Board and its compliance with accepted standards of corporate governance.						
Health & Care Standards	Access to the Standards can be obtained from the following link. www.wales.nhs.uk/siteplus/documents/1064/Easy%20Read%20Standards%20FINAL%20December%202010.pdf Standard 1. Governance & Accountability.						
Workforce	No impact.						
Freedom of Information Status	Open						

STANDARDS OF BEHAVIOUR POLICY
DECLARATIONS OF INTEREST / REGISTER OF GIFTS AND HOSPITALITY

1. SITUATION / PURPOSE OF REPORT

To provide the Audit Committee with information following receipt of the annual declarations of interest from Health Board staff and the Register of Gifts and Hospitality for the period April 2018 to date.

2. BACKGROUND / INTRODUCTION

The Health Board's Standards of Behaviour Policy ensures that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Declarations of Interest

As Members will be aware, the Standing Orders and Standards of Behaviour Policy of the Health Board set out the arrangements for Directors and other senior staff to declare interests that are relevant and material to the business of the Health Board and any interests are entered into a Register that is available for inspection by the public at the Health Board Offices. An annual review of recorded interests is conducted and all Directors are required to confirm their entry in the Register.

There is also a requirement for staff to declare 'relevant and material' interests held by their spouse or partner. This is because the pecuniary interest of one partner shall, if known to the other, be deemed to be also an interest of the other and as such must be disclosed.

"Relevant interests" will include:

- Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies;
- Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;
- A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team;

- Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
- A position of authority in a charity or voluntary body in the field of health and social care;
- Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests;
- Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.

Annual Review

All appropriate staff have been asked to complete their declaration (including a nil return). This report details for the Audit Committee the nil returns received, the number of outstanding declarations and the nature of any interests declared by Health Board Staff.

The table below provides information on progress to date:

Declarations of Interest	**2015**	**2016**	**2017**	***2018 /2019**
Issued / targeted	338	403	684	668
Returned 'No Interests'	136	216	440	348
Returned with 'declared interests'	92	129	129	205
Outstanding	110	58	115	115
Compliance Rate	67%	86%	83%	83%

***Note 2018/19 is currently in progress.**

Health Board Returns

Under the Health Board Standing Orders, the Board Members are required to complete a declaration of interest annually and this was reported within the approved Annual Report. For ease of reference, these are attached at **Appendix 1**.

Nil Returns

Under the requirements of the Standards of Behaviour policy, senior staff are required to complete a declaration of interest annually which includes "Nil Returns" and these are attached as **Appendix 2**.

Nature of Interests Declared

The nature of any interest declared by Health Board staff is set out in **Appendix 3** and the Audit Committee is asked to consider this appendix and confirm that it is content that no conflict of interest is apparent from the information received.

Outstanding Declarations

At the time of preparing this report, there remains a substantial number of declarations not returned. Most of those not returned are from clinical staff and some are from staff at Band 8 who have been asked for the first time to complete a declaration of interest. At the time of report there are 115 outstanding returns.

The lists of staff in each directorate who have not completed their declaration of interest have been sent back to the Directorate Manager and Clinical Director for action; the Executive Director has also been a copy recipient and these are set out in **Appendix 4**. The staff have now been provided a last chance opportunity to complete their declarations prior to further action by the directorates. An oral update on progress will be provided at the meeting.

Gifts, Hospitality and Sponsorship

Gifts

A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events / conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted.

The appropriate Director and the Director of Governance / Board Secretary should be advised immediately.

Hospitality

Hospitality is where there is an offer of food, drinks, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours.

Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Sponsorship

Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts and research and development.

No sponsorship should be accepted without the prior agreement of the appropriate Corporate / Clinical Director. A Gifts, Hospitality and Sponsorship Form should also be completed prior to the acceptance of any sponsorship.

If sponsorship is inappropriately offered and / or declined this should also be declared.

Attached at **Appendix 5** is the Health Board Gifts, Hospitality and Sponsorship Register covering the period July 2018 – October 2019.

CONCLUSION

Further action will continue to be taken to increase the numbers of staff completing their annual declaration of interest form. Directorates will also receive their own version of the register in order to be fully aware of any interests held by their staff.

4. RECOMMENDATION

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

- **RECEIVE** and **NOTE** the report and supporting appendices in relation to the Health Board's Standards of Behaviour Policy; and

- **NOTE** the ongoing actions being taken to improve compliance.

Freedom of Information Status	Open

Appendix 2

CWM TAF MORGANNWG HEALTH BOARD

DECLARATION OF INTERESTS 2018/19 – NIL RETURNS

NAME	DESIGNATION
Executive Directors/Board Members	
Alan Lawrie	Director of Primary Care, Community & Mental Health
Angela Hopkins	Interim Executive Director of Nursing, Midwifery and Patient Care
Collette Kiernan	Chair, Health Professionals Forum
Giovanni Isingrini	Associate Board Member
Joanna Davies	Director of Workforce & Organisational Development
John Palmer	Chief Operating Officer
Kamal Asaad	Medical Director
Lynda Williams	Director of Nursing, Midwifery & Patient Services
Paul Griffiths	Independent Member
Robert Smith	Independent Member
Ruth Treharne	Deputy Chief Executive/Director of Planning & Performance
Stephen Harrhy	EASC/Board Director
Steve Webster	Director of Finance
Acute Medicine and Accident & Emergency	
Elizabeth Slowinska	Consultant Gastroenterologist
Sarah E Elliott	Specialty Doctor Palliative Care
Gautam Das	Consultant Physician
Deborah Pritchard	Senior Nurse Medicine
Elizabeth Stevenson	Consultant in Emergency Medicine
Claire Jones	Interim Senior Nurse
Leila El-Dars	Consultant Dermatologist
Ihmoda Ahmad Ihmoda	Consultant Physician
Robert Bleasdale	Consultant Cardiologist
Richard Dewar	Consultant Physician
Deborah Harris	Head of Nursing
Dave Tyler	Head of Cardiopulmonary Diagnostics
John Huish	Consultant Cardiologist
James White	Consultant Physician
Kate Speed	Consultant Acute Physician
Vikas Lodhi	Consultant Acute Medicine
Joanne Morris	Consultant in Acute Medicine
Julie Martin	Consultant Dermatologist

Appendix 2

NAME	DESIGNATION
Ruth Alcolado	Consultant Physician
Philip Evans	Consultant, Diabetes
Ahmed Kamal	Consultant in Emergency Medicine
Julie West	Senior Nurse
Chandranath Sarkar	Consultant General Internal Medicine
Bee Leng Lee	Consultant Gastroenterologist
Shuann Shwana	Consultant
Melanie Fuller	Nurse Endoscopist
Charles Thomas	Consultant Dermatologist
Robin Martin	Consultant Physician
Nerys Conway	Consultant in Acute Medicine
David L Whitehead	Specialty Doctor
Sarah McGrath	Senior Nurse
Emma Collins	Specialty Doctor in Palliative Care
Rhian Goodfellow	Consultant Rheumatologist
Rachel Owen	Lead Nurse Cardiology
Rhodri Martin	Consultant in Sport & Exercise Medicine
Asim Bilal	Locum Consultant ED
Eugene Tabiow	Consultant in Acute Medicine
Anthony Gibson	Consultant, Medicine
Govardhan Navaratnam	Consultant Cardiologist
Mridul Biswas	Consultant in Mental Health
Paula Claire Williams	Consultant Cardiologists
Peter Neville	Consultant Gastroenterologist
Rhiannon Bowen	Advanced Nurse Practitioner
Robin Martin	Consultant Physician
Victoria Brooks	Cardiac Physiologist
Catherine Templeton	Head of Echocardiography
Shehnoor Tarique	Consultant Physician (Chest)
Amit Benjamin	Consultant Physician
Nia Rathbone	Consultant in Acute Medicine
ACT Directorate	
Bethan Gibson	Consultant Anaesthetist
Najia Hasan	Consultant Anaesthetist and Intensivist
Jason Butcher	Consultant Anaesthetist
Martin Cole	Consultant Anaesthetist
Girish Girish	Consultant Anaesthetist
Cheryl Davies	Senior Nurse
Kochueettil Gopa Kumar	Consultant Anaesthetist

Appendix 2

NAME	DESIGNATION
Andrew Herman	Senior Nurse
Neela Tailor	Consultant Anaesethetist
Vikram Sinha	Consultant Anaesethetist
Richard H Jones	Consultant Anaesethetist
Simon A Reid	Consultant Anaesthetist
Daniel Bruynseels	Consultant Anaesthetist
Dariusz Tetla	Consultant Anaesthetist
Tarek Saleh	Consultant Anaesthetist
Babak Sedhi	Consultant Anaesthetist
Ashish Wagle	Consultant Anaesthetist
Ranj Khaffaf	Consultant Anaesthetist
Valerie Hilton	Consutlant Anaesthetist
Matthew Williams	Consultant Anaesthetist
Neil Cooper	Directorate Manager
Claire Halligan	Consultant Anaesthetist
Helen Williams	Senior Clinical Nurse Specialist – Pain Management
Piroska Katalin Toth-Tarsoly	Consultant Anaesthetist and Intensivist
Kathryn Lloyd-Thomas	Consultant Anaesthetist
Geraint Rees	Consultant Anaesthetist
Brian Jenkins	Honorary Consultant
Szabolcs Kalman	Consultant Anaesthetist
Moayed Aziz	Consultant Anaesthetist
David J Jones	Consultant Anaesthetist
Dermot Cremin	Consultamt Anaesthetist
Richard Roberts	Consultant Anaesthetist
CAMHS Directorate	
Isobel Davey	Consultant in Child & Adolescent Psychiatry
Laura Morris	Clinical Psychologist
Callista Hettiarachchi	Consultant in Child & Adolescent Psychiatry
Anna Rachel Goel	Consultant Child & Adolescent Psychiatrist
Richard Down	Consultant Clinical Psychologist
Gill Salmon	Consultant
Gail Clack	Interim Deputy Head of Nursing CYP & CAMHS
Julie Cude	Deputy Head of Nursing
Peter D Halford	Consultant in Child & Adolescent Psychiatry
Abigal Willis	Consultant Clinical Psychologist
Caroline Hoskins	Clinical Psychologist
Christina Morgan	Senior Nurse Manager

Appendix 2

NAME	DESIGNATION
Jane Jones	Consultant Child & Adolescent Psychiatrist
Kim Palmer	Senior Clinic Nurse Specialist
Chris Coslett	Directorate Manager
Elissa Lewis	Family Therapist
Sheriffa Dalrymple	Consultant
Miram Cooper	Consultant Child & Adolescent Psychiatrist
James Feeney	Clinical Psychologist
Claire Ball	Consultant in CAMHS
Joanne Buchmuller	Family Therapist CAMHS
Angela Davies	Clinical Nurse Specialist CAMHS
Sanjay Chugh	Consultant Child & Adolescent Psychiatry
Jane O'Kane	Head of Nursing, CYP & CAMHS
Sunil Pulapaka	Consultant in CAMHS
Ahmed Darwish	Consultant in child and adolescent Psychiatry
Susan Vaughan	Senior Primary CAMHS Specialist
Tracey Davies	Specialist Nurse Practitioner
Eve Bowyer	Clinical Psychologist
Chief Executive Office	
Kimberley Cann	Consultant in Public Health
Children & Young People Directorate	
Ezzat Afifi	Consultant Paediatrician
Nasrean Haddad	Consultant Paediatrician
Meryl Wilshire	Senior Nurse Paediatrics
Lynne Millar-Jones	Consultant Paediatrician
Sami Khan	Consultant Paediatrician
Zedekiah Sibanda	Consultant Paediatrician
Poonamallee Govindaraj	Consultant Paediatrician
Allyson Allman	Senior Nurse Health Visiting
Bethan Thomas	Consultant Paediatrician
Ashraf Elhenawy	Consultant Paediatrician
Chris Moulds	Deputy Directorate Manager
Susan Jones	Senior Nurse Health Visiting, Flying Start
Sadasivam Arun	Consultant Paediatrician
David Deekollu	Consultant Paediatrician
Humphrey Okuonghae	Consultant Paediatrician
Farah Khan	Consultant Paediatrician
Farah Mushtaq	Consultant Paediatrician
Katie Taylor	Advanced Neonatal Nurse Practitioner

Appendix 2

NAME	DESIGNATION
Lisa Thomas	Paediatric OT Technician
Lynne Hannington	Senior Nurse
Ryan Williams	OT Assistant Practitioner
Katherine Gale	Consultant Community Child Health
Commissioning	
Gina Southam	Systems Accountant
Julie Keegan	Assistant Director of Commissioning
Corporate Services	
Andrew Francis	Civil Contingencies Manager
Emyr Jones	Personal Safety Adviser
Paul Edmonds	Communications and Engagement Manager
Julia Sumner	Assistant Head of Communications
Estates & Facilities	
Jason Williams	Operational Maintenance Manager
Christopher Scully	Senior Estates Manager
Christopher James	Head of Contracts and Purchasing Performance
Bernard Carter	Senior Projects Manager
Bill Rogers	Programme Director
Russell Hoare	Head of Facilities
David Williams	Head of Information
Stephen Barnard	Head of Catering Business Service/Health Board Advisor
Robert David	Senior Estates Officer
Jeffrey Chard	Linen Services Manager
Catherine Ann Pugh	Deputy Linen Services Manager
Richard Knowles	Facilities Manager
Claire Masters	Facilities Manager
Alan Martin	Head of Operational Estates
Wayne Lewis	Patient Transport Service – Senior Manager
Finance & Performance	
Sue Holroyd	Assistant Director of Finance
Shane Evans	Head of Finance Corporate Functions
Robert Hugh Slade	Finance Manager Scheduled Care
Kendal Smith	Head of Financial Flows
Alison Moroz	Finance Manager, Contract & Commissioning
Ana Riley	Head of Finance
Mark Thomas	Deputy Director of Finance
Sarah Taylor	Finance Manager
General Surgery, Trauma & Orthopaedics and Urology	
Claire Louise Powell	Senior Nurse

Appendix 2

NAME	DESIGNATION
Keryn Jones	Lead Urology Nurse Practitioner
Michael Pollitt	Consultant Surgeon
Mike Davies	Clinical Coordinator Trauma & Orthopaedics
David Cotton	Consultant Surgeon
Lisa Williams	Consultant Trauma & Orthopaedic Surgeon/Clinical Director
Anne Jane French	Consultant Urologist
Maria Lewis	Colorectal CNS
Miriam Day	Consultant in Trauma & Orthopaedics
Ajay Sharma	Consultant Orthopaedic Surgeon
Peter Evans	Consultant Surgeon
Ashraf Masoud	Consultant
Parin Shah	Consultant Surgeon
Paula Pearce	Directorate Manager
Gary Osborn	Consultant Breast Surgeon
Nader Naguib	Associate Specialist
Donna Seldon	Senior Nurse
Rhian Searle	Interim Senior Nurse, Theatre, Pre-assessment & Pain
Deborah Cairns	Consultant Surgeon
Gayle Williams	Staff Nurse – Directorate Office
Maria Jones	Staff Nurse – Stoma Breast Care
Mohammed Khalid Zia	Locum Consultant in General Surgery
Head & Neck Directorate	
Keith Smart	Consultant Maxillofacial
Jonathan Arthur	Head of Audiology
Vijay Singh	Consultant ENT Surgeon
Mark Deacon	Head of Orthoptics Services
Peter Nicolson	Consultant Orthodontist
Jason Ingham	Dental Laboratory Manager
David RK Smith	ENT Consultant
Nasreen Yaqoob	Consultant – Orthodontics
Jonathan Hulbert	Locum Consultant in Oral and Maxillofacial Surgery
ICT	
Karen Winder	Head of Clinical Systems
Paul Chilcott	Head of Server Management
Christopher Ball	Head of ICT Infrastructure

Appendix 2

NAME	DESIGNATION
Information & Performance	
Rita James	Head of Benchmarking
Alan Roderick	Assistant Director of Performance & Information
Localities Directorate	
Lesley Lewis	Head of Primary Care & Localities
James Chambers	Primary Care & Community Estates Development Manager
Lucie Williams	Interim Deputy Head of Nursing
Rebecca Spicer-Thomas	Lead Nurse Advance Care Planning
Alison Lagier	Locality Manager
Nicola Lewis	Locality Lead for Merthyr PSCU
Andrea Dorrington	Lead Advance Nurse Practitioner Community Hospitals
Rhys Roberts	Senor Nurse District Nursing
Paula Marie Cooper	Lead Nurse Palliative Care
Mair Thomas	Senior Nurse
Keith Powell	Business Manager Community Services
Ian Back	Consultant in Palliative Care
Dylan Harris	Consultant in Palliative Medicine
Victoria Wheatley	Consultant in Palliative Medicine
Susan Zobole	Community Services Manager
Paul Crank	Deputy Head of Nursing (Primary Care & Localities)
Michelle Lloyd	Macmillan End of Life Care Modernisation Manager
Jacqueline Morgan	Advance Nurse Practitioner
Sian Lewis	Nurse Manager
Medicines Management	
Rachel Truscott	Cluster Pharmacist
Melissa Siew	Clinical Pharmacist
Christine Vining	Pharmacist
Charlotte Pearce	Pharmacist
Rhianydd Nash	Pharmacist (Mental Health)
Kate Walker	Chief Pharmacist Medicines Governance
Beverley Woods	Pharmacist
Giovanna Nelms	Clinical Lead Pharmacist
David McRae	Pharmacy Team Leader
David Jenkins	Clinical Pharmacist
Anthony Cadogan	Pharmacist
Rhys Thomas Evans	Pharmacist
Irram Irshad	Pharmacist
Jane Hardwidge	Pharmacist Team Leader

Appendix 2

NAME	DESIGNATION
Charlotte Pritchard	Cluster Pharmacist
Claire Collins	Pharmacist
Helen Morteo	Pharmacist
Daniel Phillips	Antimicrobial Pharmacist
Liza Lindell	Clinical Pharmacist
Ann-Marie Montolo	Principal Pharmacist Patient Services
Helen Self	Primary Care Pharmacist
Sonia Attley	Pharmacist Team Leader
Gillian Timm	Pharmacy Team Leader Educational Training
Geraint Jones	Advanced Pharmacist HIV & Homecare
Angela Godfrey	Pharmacist
Emma Williams	Lead Pharmacist Community
Christine Vining	Pharmacist
Lisa Lindell	Pharmacist
Nicole Gibbs	Medicine Management
Martin Davies	Chief Pharmacist Community Services
Emma Brierley	Secondary Care Advanced Pharmacist
Irram Irshad	Cluster Pharmacist
Gwenno Roberts	Clinical Trials Pharmacist
Giovanna Nelms	Clinical Lead Pharmacist
Rhian Smith	Pharmacist
Jenny Harries	Chief Pharmacist, Clinical Services
Simon Kingsbury	Pharmacist Team Leader, Aseptic Service
Nadia Higgi	Respiratory Pharmacist
Mark Allman	Chief Pharmacist
Sarah Griffiths	Acute Stroke Pharmacist
Amanda Halloway	Pharmacist
Angharad Thomas	Advanced Pharmacist
Anne-Marie Montoto	Principal Pharmacist Patient Services
Fiona Hyde	Primary Care Pharmacist
Gabriella Booth	Antimicrobial Pharmacist
Rowena Harvard	Formularly Pharmacist
Sarah Walker	Prescribing Advisor
Julie Davies	Pharmacist
Rhys Evans	Pharmacist
Thomas Few	Pharmacist
Mental Health Directorate	
Johnathan M Smith	Locum Consultant
Arif Alam	Locum Consultant

Appendix 2

NAME	DESIGNATION
Natalie Reilly-Johnson	Clinical Psychologist
Mary Self	Consultant Psychiatrist
Rajkumar Lakshmanan	Consultant Psychiatrist
Sunil Joseph	Consultant Psychiatrist
Claire Goatson	Senior Nurse Older Peoples Mental Health
Julie Denley	Assistant Director of Operations
Bhushan Vaidya	Consultant
Rhoswen Hailwood	Consultant
Lucy Timlin	Directorate Manager Mental Health
Jeanne Smith	Director
Jenna Ivey-Williams	Clinical Psychologist
Tracy Carlson	Consultant Clinical Psychologist
Gary Sullivan	Consultant Psychiatrist
Hazel Mills	Clinical Psychologist
Debra Pennell	Senior Manager
Sajitha Koratala	Consultant
Graeme Karger	Clinical Psychologist
Kim Williams	Consultant Clinical Psychologist
Julian Pitt	Consultant Clinical Psychologist
Adarsh Shetty	Consultant Rehabilitation Psychiatrist
Caroline Durrant	Principal Psychologist
Sudantha Fernando	Consultant Psychiatrist in Substance Misuse
Raman Sakhuja	Consultant Psychiatrist
Juan Delport	Head of Psychology Services
Sylvia Baker	Consultant Psychiatrist
Fiona Senior	Clinical Psychologist
Jeanne Smith	Directorate Support Manager
Jemma Chambers	Clinical Psychologist
Lynne Garwood	Advanced Nurse Practitioner
Mark Griffiths	Senior Nurse, Mental Health
Neil Thomas	Consultant Psychiatrist
Richard Neil Evans	Lead for Clinical Ethics
Samantha Shore	Senior Nurse
Timothy Dye	Consultant Psychiatrist
Obstetrics & Gynaecology Directorate	
David H O Pugh	Consultant Gynaecologist
Kerri Eilertsen-Feeney	Head of Midwifery
Julie Evans	Senior Midwife
Helen Marx	Consultant in Obstetrics & Gynaecology

Appendix 2

NAME	DESIGNATION
Debbie Griffiths	Senior Midwife
Suzanne Williams	Interim Senior Nurse
Amanda Smith	Clinical Nurse Specialist in Colposcopy
Kim Jenkins	Senior Clinical Midwife
Jonathan Rogers	Consultant in Obstetrics & Gynaecology
Helen Jones	Senior Clinical Midwife
Zoe Ashman	Risk & Governance
Amie Symes	Senior Midwife
Tarek Allouni	Directorate Manager
Catrin Rees	Senior Midwife
Jonathan Pembridge	Consultant in Obstetrics and Gynaecology
Operations Management	
Wayne Jenkins	Head of Business and Operational Support
Dana Knoyle	Single Cancer Pathway Clinical Lead
Pathology Directorate	
Mark Henry	Biochemistry Immunology POCT Service Manager
Alexandra Marie Thomas	Biomedical Scientist
Alan Dodd	Principal Clinical Scientist
Mark Tudor Jones	Cellular Pathology Operations Manager
Lynne Meeke	Haematology Nurse Manage/CNS
Sarah Elizabeth Antcliff	Consultant Haematologist
Tammy Payne	Blood Transfusion Services Manager
Rhiannon Webb	Cellular Pathology and Mortuary Service Manager
Paul Seddon	Pathology Quality Manager
Waleed Mumar-Bashi	Consultant
Rupali Rajpurohit	Consultant Microbiologist
David Cassidy	Consultant Chemical Pathologist
Joanna Williams	Directorate Manager
Alison King	Chief BMS
Bethan Cradle	Lead Infection Prevention and Control Nurse
Michael Melhuish	Immunology Service Manager
Priya Dewan	Consultant
Rebecca Hopson	Blood Sciences Site Manager PCH
Sara De Vries	Consultant Histopathologist
Patient Care & Safety	
Alison Davies	Assistant Director of Quality & Patient Experience
Pauline Griffiths	Senior Nurse Revalidation

Appendix 2

NAME	DESIGNATION
Kellie Jenkins-Forrester	Senior Manager for Investigations & Quality Improvement
Louise Mann	Head of Safeguarding
Debra John	Lead Nurse for Looked After Children
Amanda Cassidy	Interim Assistant Director of Nursing
Ruth Friel	Head of Patient Experience
Kathryn Doughton	Patient Experience Manager
Mark Townsend	Head of Clinical Audit and Quality Informatics
Beverley Brooks	Deputy Head of Nursing (Safeguarding)
Planning & Partnerships	
Claire Williams	Transition Programme Manager
Elaine Williams	Head of Performance & Clinical Information
Lindsey Richardson	Head of Planning, Primary Community & Mental Health
Marie Evans	Head of Planning Unscheduled Care
Fiona Thomas	Project Manager
Clare Williams	Assistant Director of Planning & Partnerships
Paul Lewis	Head of Assets, Governance & Technical Services
Sharon Jeynes	Senior Manager
Rebecca Luffman	Senior Manager
Nicola Davies	Senior Manager
Primary Care Directorate	
Mark Gall	Deputy Manager
Martine Randall	Development Manager
Fiona Wood	Senior Nurse
Sarah Bradley	Directorate Manager, Primary Care & Localities
Harry Hunt	Clinical Director, GP Out of Hours
Kimberly Dunn	Primary Care Manager
Hayley Pugh	Deputy Manager
Timothy Palmer	Independent Optometry Advisor
Radiology Directorate	
Ahmed Vali	Consultant Radiologist
Kieran Foley	Consultant Radiologist
Christopher Williams	Consultant Radiologist
Osama Hussein	Consultant Radiologist
Alison Yates	Consultant Radiologist
Jean Marc-Soukias	Consultant Radiologist
Eleanor Morris	Consultant Radiologist
Timothy Pearce	Consultant Radiologist

Appendix 2

NAME	DESIGNATION
Kate Gower Thomas	Consultant Radiologist
Gareth J Davies	Consultant Radiologist
Stuart Baines	Clinical Specialist Radiographer
Marc Phillips	Superintendent Radiographer
Collette Jones	Superintendent Radiographer
Carys Jenkins	Consultant Radiologist
Victoria Whitchurch	Academy Manager
Fahad Mewazy	Consultant Radiologist
Paul Johnston	Superintendent Radiographer
Lynne Francis	Superintendent Radiographer
Marc Phillips	Superintendent Radiographer
Alan Lewis	Directorate Manager
Grant Griffiths	Consultant Radiologist
Therapies Directorate	
Fiona Dunn	Clinical Lead for Dementia SLT
Victoria Barrett	Principle Speech & Language Therapist
Judith Chidgey	Speech & Language Therapist
Angela Bell	Therapies Clinical Quality Manager
Alice Reed	Head of Nutrition & Dietetics
Vanessa Hayward	Head of Speech and Language Therapy
Denise Jenkins	Head of Podiatry & Orthotics
Victoria Collins	Speech and Language Therapist
Emma Jenkins	Dietetic Operational Lead Paediatrics
Sarah O'Connor	ALN Clinical Transformational Lead
Zoe Brewster	Physiotherapy Professional Manager
Hilary Mott	Physiotherapy Manager
Debbie Davies	Head of Physiotherapy Services
Andrea Russ	Deputy Head of Nutrition Services
Bryan Watters	Deputy Head of Podiatry & Orthotic Services
Lisa Medhurst-Wroe	MSK Clinical Specialist Physiotherapist
Sarah Lewis-Simms	Principal Occupational Therapist
Alyson Davies	Assistant Director of Therapies & Health Sciences
Ceri James	Dietetic Operational Lead
Paula Cornelius	Interim Head of Occupational Therapy Services
Jonathan Hopkins	Occupational Therapy Technician
Julie Thomas	Occupational Therapist
Tracey Daniel	Occupational Therapist
Tracey Cooper	Occupational Therapist Technician
Jade Price	Occupational Therapist

Appendix 2

NAME	DESIGNATION
Laura Williams	Occupational Therapist
Jean Gough	Occupational Therapist Assistant
Tania Carter	Occupational Therapist Technician
Hazel Fraser	Therapy Technician
Nataliya Williams	MAS Occupational Therapist
Ana Hemborough	Rotational Occupational Therapist
Emma Hughes	Clinical Specialist OT for Paediatric Neurodisability
Lisa Jones	Clinical Support Worker Occupational Therapy
Helen Ellis	Technical Instructor Therapies
Melanie Kaler	Occupational Therapy Technician
Rebecca Reaney	Occupational Therapy
Nia Gibbon	Paediatric Occupational Therapist
Elain Huws	Occupational Therapist
Kerstin Ackermann-Lloyd	Occupational Therapist
Vivien Owen	Occupational Therapist
April Brooks	Occupational Therapy Assistant
Menna Payne	Clinical Lead SLT
Tanya Horton	Chief Paediatric Audiologist
Gaynor Griffiths	Podiatrist
Emma L Francis	Highly Specialist Occupational Therapist
Danny Thomas	OT Technician
Leah Price	OT Technician
Karen Lepore	Podiatrist
Rebecca Davies	Podiatrist
Annest Owens	Highly Specialist OT Team Lead ESD
Alison Docherty	Macmillan Specialist Occupational Therapist
Rhian Smith	Pharmacist
Jenny Harries	Chief Pharmacist Clinical Services
Cathryn Lewis	Memory Assessment Service Occupational Therapist
Matthew Elwell	Assistant Practitioner (OT MAS)
Tracy Davies	Podiatrist
Louise E Evans	Podiatrist
Janet Bevan	Principal Occupational Therapist
Madelaine Najjar	Dietetic Operational Lead
Angela Arentsen	Principal Occupational Therapist
Caroline Paula Williams	OT Technician ESD
Claire Griffiths	Occupational Therapist
Claire Young	Highly Specialist Occupational Therapist

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NAME	DESIGNATION
Dolina Morris	Principle Paediatric Physiotherapist
Elizabeth Bufton	Occupational Therapist
Emma Lewis	Podiatrist
Emma Ralph	Team Manager – Stay Well @ Home
Hayley Proctor	Rotational Physiotherapist
Helen Davies	Occupational Therapy Technical Instructor
James Hancock	Paediatric Occupational Therapist
Janet Hodges	Occupational Therapy Assistant Practitioner
Jeanette Slade	Team Lead Occupational Therapist
Jill Foster	Occupational Therapist
Johanna Poupon	Occupational Therapy Technical Instructor
John Keith Evans	Highly Specialist Occupational Therapist
Julie Browning	Occupational Therapist
Karen Jones	Physiotherapy Manager (8a)
Karen Williams	Occupational Therapist
Kelly Ford	Occupational Therapist
Kerry Thomas	Paediatric Occupational Therapist
Kimberley Gover	Paediatric Occupational Therapist
Rachael Edwards	Occupational Therapist – Stay Well @ Home
Rachael Gdesis-Evans	Principal Occupational Therapist
Stacey James	Dietetic Operational Lead
Susan Rothwell	Senior Occupational Therapist
Vikki Williams	Occupational Therapist
Wanda Foster	Advanced Occupational Therapist Practitioner
Zoe Parker	Occupational Therapist
Zoe Williams	Occupational Therapist
Workforce & OD	
Hywel Daniel	Deputy Director Workforce & Organisational Development
Jayne Dando	Assistant Director of Workforce Transition
Donna Hill	Interim Assistant Director of Workforce & OD
Janet Gilbertson	Interim Assistant Director of Organisational Development
Angela Jones	Programme Manager Workforce Activity
Claire Nicholas	Head of Workforce Improvement and Efficiency
HOSTED BODIES	
Chris Moreton	Head of Finance, National Collaborative Commissioning Unit

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NAME	DESIGNATION
Anthony Hayward	Assistant Director of National Collaborative Commissioning Service

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CWM TAF HEALTH BOARD
DECLARATIONS OF INTEREST 2018/19

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
ACT Directorate			
	Latha Srinivasa	Consultant Anaesthetist and Intensivist	• I have been practicing privileges at the following hospitals:- Spire Hospital, Cardiff; Nuffield Hospital Vale; London Women's Clinic, Cardiff.
	David R Price	Locum Consultant Anaesthetist	• Bank Consultant Anaesthetist at Emersons Green Treatment Centre, run by Care UK. Ad hoc sessions - only 2 in last 12 months. Mixture of NHS patients, self-funded and insurance paid patients for elective surgical procedures. • Parent Governor of son's school - Durand Primary School, Caldicot, Monmouthshire.
	Peter Fitzgerald	Consultant Anaesthetist	• Medical Director, All Wales Ambulance Service
	Dom Hurford	Consultant Anaesthetist	• Chairman of the "Welsh Frailty Fracture Network".
	Doddamanegowda B Chetham	Consultant Anaesthetist	• Registered at the following hospitals to do private work:- Spire Hospital, Cardiff; Nuffield Hospital, Cardiff ; Londen Women's Clinic, Cardiff. Not done any clinical work at the above clinics for over 12 months.

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	Oma Alex Pemberton	Consultant Anaesthetist	• The Society of Anaesthetists of Wales is an educational charity which promotes anaesthesia in the Principality. The role of Honorary Secretary is voluntary and unpaid. • Honorary Secretary of Society of Anaesthetists of Wales.
	Neeraj Saxena	Consultant	• Directorship of private company. • Private practise- Spire Cardiff, Nuffield Vale, Bridgend Clinic. • Posts held at South Wales Network of acute pain network and Welsh pain society. • Sponsored educational meeting from Astellas pharmaceuticals.
	Rutton Hilloowalla	Consultant Anaesthetist	• Part of a team providing anaesthetic service at the London Women's Clinic in Cardiff.
	Majd Al Sharmaa	Consultant Anaesthetist	• Honorary Tutor, Case Manager Medic Support Cardiff University School of Medicine Institute of Medical Education College of Biomedical and Life Sciences
Acute Medicine & Accident & Emergency Directorate			
	Paul Neill	Consultant	• Locum respiratory consultant at St John's Hospital Limerick Ireland last year. This

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			was in annual leave time and was for 5 working days in November 2018.
	Clive Tovey	Consultant In A&E	• Councillor and currently Mayor of the County Borough of Merthyr Tydfil. • An Airbnb registered for his home. • Owns Pant Supermarket and Post Office. • On Mid Glamorgan Council of St John
	Sinan Eccles	Consultant Physician	• Wife is a locum GP who occasionally works in Cwm Taf GP practices. • Editor of a revision question bank for the website StudyPRN. • Involved in work on guidelines with NICE and British Thoracic Society. • 5+ years with NICE.
	Leslie Ala	Consultant Acute Physician	• Wife is a Cardiac Physiologist (ECHO) at Royal Glamorgan Hospital. • Provides clinical advice in General and Acute Medicine to the Public Service Ombudsman of Wales. • Honorary Senior Lecturer for Year 3 (Cardiff University Medical School) for Cwm Taf UHB.
	Lalit Bhalla	Consultant Cardiologist	• Some private work which includes seeing private patients and carrying out private investigations including echocardiograms and stress echocardiograms. Private

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			income from this goes into my limited company called LEEA Health Ltd.
	Justin Taylor	Consultant Cardiologist	• Small amount of private practice work in the Vale Hospital, Cardiff, and also in Prince Charles Hospital outpatients. • Medical Advisor for the charity Welsh Hearts.
	Minesh Patel	Consultant Physician	• Registered to see private patients at Nuffield Health May 2018.
	James Martin	Consultant Rheumatologist	• Private practice as a Consultant Rheumatologist with Nuffield Health. Private practice undertaken at Cardiff Bay clinic, Cardiff • Private practice - report DXA scans for Medica - a remote reporting radiology company. Undertaken at Regis Building, Cardiff Gate.
	Ritabrata Mitra	Consultant Cardiologist & Physician	• Private practice at Spire Hospital, Cardiff – long term.
	Christopher Hodcroft	Consultant Acute Physician	• Member of the Council and Company Director of the Society For Acute Medicine (non-remunerated.)
	Rachel Criddle	Mcmillan Clinical Psychologist	• Undertakes private practice 1-2 days a week after work, for a maximum of 3 hours. This is in Cardiff. Does not see clients from Rhondda Cynon Taf, or Merthyr area during her private practice.

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	Sandra Davies	Clinical Scientist/Deputy Manager CPU	• Aligned with CRY Charity. • Aligned with Wolverhampton University
	Victoria Goodwin	ED Consultant	• Husband is the Director of South Wales Knee Clinic. • I have become a co-director of this company. My husband treats private patients in Saint Joseph's Hospital under his company name. He is an orthopaedic surgeon whose main employment is Aneurin Bevan UHB. I do not treat patients there and I do not refer patients to him privately.
	Emyr Humphreys	Consultant Rheumatologist	• Pharmaceutical Company UCB covered the cost of attending the ASAS Spondyloarthropathy Meeting in Brussels in October 2015, including course, flight and hotel. No payment received. • Pharmaceutical company Celgene sponsored my attendance as a delegate at EULAR conference in Amsterdam in June 2018, covering conference fee, flight and hotel. No payments received.
	James Berrill	Consultant Gastroenterologist	• Speaker Fees from Abbvie. • Consultation Fees from Janssen. • Travel/Conference sponsorship MSD

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	John Geen	Consultant Clinical Biochemist/Assistant Director R&D	• Wife works for Cwm Taf UHB. • Consultancy work for Simbec Laboratories, Merthyr Tydfil. • Chair of the Association of Clinical Biochemistry and Laboratory Medicine and through affiliation an Executive Member of the Council for the Association of Clinical Biochemistry and Laboratory Medicine. • Regional Tutor for the Association of Clinical Biochemistry and Laboratory Medicine. • Professor of Clinical Science, University of South Wales.
	Atkul Kalhan	Professor Endocrinology	• • I along with 3 of my Diabetes & Endocrinology consultant colleagues (Dr Anil Kumar & Dr Vinay Eligar based at Cardiff & Vale University Healthboard and Dr Maneesh Udiawar based at Moriston hospital) are directors of a company (Medtrend limited). We organise and teach primary care physicians twice a year on common Diabetes & Endocrinology related topics. These study days are free of charge and organised on Weekends during our own time.

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			• • Date of Appointment • Nature of Interest 01 • This is a free study day done twice yearly on a weekend. I do this initiative as part of my own interest to teach and spread awareness regarding management of common Diabetes & Endocrinology related dysfunctions. I have no financial incentive in this venture and any sponsorship money by pharmaceutical companies is used to arrange venue (Cardiff University lecture theatres) and catering to the delegates. As company directors we have developed a basic website (www.diabendo.co.uk) and keen to expand it in future.
	James Bolt	Consultant in COTE	• "Sponsored by Brtitania Pharmatceuticals to attend a Controversies in Neurology conference in Berlin in 2013. Attended for CPD. • Paid lecture for UCB Pharma November 2015 to promote Cwm Taf University Health Boards Acute care of Parkinson's Disease patients. The money (£500) was given to the Cwm Taf Parkinsons fund and I did not benefit from this. Paid

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			lecture on sleep and its treatment in hospital. The lecture was a GP evening event sponsored by Flynn Pharma. I was paid £400. I purchased medical equipment with this money for use in my current role Sponsored by Britannia Pharma to attend a conference on Apomorphine in London in 2017 • Attended allergan Course in 2017 x2 for the administration of BOTOX to both dystonic and stroke patients Lectured for ucb pharma DECEMBER 2017 - new guidelines for CTUHB. Paid 500 pounds • Lectured for UCB Pharma April 2018. New guidelines for CTUHB. Paid 500 pounds • Attended the days lecture.
	Manish Chebbi	Consultant in COTE	• Attending a leadership training event sponsored by a pharmaceutical company. Location: Brighton, UK • Attending a Masterclass training event on Evidence in Stroke Prevention in AF sponsored by a pharmaceutical company. Location: Barcelona, Spain. • Attending a training day on newer anticoagulants in stroke prevention, at Birmingham - training sponsored by pharmaceutical company. No

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
			accommodation or other benefit. Location: Cardiff • 1 hr teaching on Atrial Fibrillation and Stroke Prevention, and the role of Direct Anticoagulants. • Role: Consultant Speaker for Pfizer. • Interest: Honorarium of £500 agreed as a one-off contract for this presentation.
CAMHS Network Directorate			
	Sameer Awadalla	Consultant Child & Adolescent Psychiatrist	• Hold evening clinics in Cyncoed Consulting Rooms where young patients are sees for assessment and management of mental health difficulties.
	Jonathan Chatham	Highly Specialist Family Therapist	• Provides consultation to the Barnardo's Emotional Well-being Service in Cardiff.
	Samantha Ames	Consultant Child & Adolescent Psychiatrist	• On June 11th 2018, started working for the ABMU Neurodevelopmental Disorders Team (7sessions) and continue to work for CAMHS in NPTH (2 sessions). Continues to be employed by Cwm Taf UHB. Husband, is currently the Medical Director at Singleton Hospital, ABMU and responsible for ABMU Neurodevelopmental Disorders Team.
	Julie Withecomb	Consultant Psychiatrist	• Undertakes medico-legal reports to report to courts and parole hearings for which I

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			am paid an hourly rate. Undertaken such reports throughout consultant career and this work is ongoing.
	Tricia Skuse	Clinical Psychologist	• Private practice offering training and consultancy on child development, attachment, trauma and youth offending. • Director of TRM Academy Ltd who provide training services on child development, attachment, trauma and youth offending.
	Jonathan Matthew	FACTs Youth Forensic Co-ordinator	• Private practice offering training and consultancy on challenging behaviour, child development, attachment, youth offending, trauma and harmful sexual behaviour in children and young people. • The trauma element of the above interest has now evolved into a limited company called 'TRM Academy Ltd' - I am a Director. No changes to the nature of the interest declared.
	Juan-Claudio Ferre	Consultant Child & Adolescent Psychiatrist	• Flyn Pharma invitation to a conference on 28 /10/2018. travel , course fees and accommodation
	Antonio Jos Munoz-Solmando	Consultant Child & Adolescent Psychiatrist	• Private Court Reports.
	Amani Hassan	Consultant Child & Adolescent Psychiatrist	• Covers Beechwood College clinically 3 sessions per month but use SPA for 1 out

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			of the 3 monthly sessions since 1/9/16. Two of the 3 sessions were carried out during weekends.
	Krishna Menon	Consultant Child & Adolescent Psychiatry	• Non remunerated director of SL Healthcare Solutions Ltd.
	Ahmed Darwish	Consultant Child & Adolescent Psychiatrist	• Director of development and Lettings Company
	Fiona Senior	Clinical Psychologist	• Husband has private practice as CBT therapist in Cardiff.
Chief Executive's Office			
	Allison Phillips	Transition Director	• Governor of the University of South Wales. Member of the Audit and Risk Assurance Committee of USW.
Children & Young People Directorate			
	Jeyashree Natarajan	Consultant Paediatrician	• Attended meetings that are subsidised by the drug companies, either as part of the departmental teaching, or external meetings and my attendance hasn't influenced my medical practice or my clinical decision making.
	Marcia Scheller	Consultant Paediatrician	• Partner works as Paediatric Consultant in same health board.
	Rainer Fortner	Consultant Paediatrician	• Partner works as a Consultant Paediatrician for the health board.
	Iyad Al-Muzaffar	Consultant Neonatologist	• Accepted invitation from Fisher & Paykel to participate in a research forum on neonatal nasal high flow nasal cannula.

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			Company funded travel expenses (Car) and overnight stay. Venue Burnham Beeches Hotel, Buckinghamshire 4th & 5th September 2018.
	Rainer Fortner	Consultant Paediatrician	• Partner works as a Consultant Paediatrician for the health board.
Corporate Services			
	Felicity Waters	Head of Communications	• Spouse/Partner – Assembly Member for Llanelli and Deputy Minutes for Economy and Transport in the Welsh Government. Health Board area represented is outside of Cwm Taf. However, any enquiries from his political office that may involve Cwm Taf University Health Board, or any of its host bodies, ie WHSSC, EASC and CAMHS would be dealt with by the Health Secretary.
	Wendy Penrhyn-Jones	Head of Corporate Administration	• Husband works for Cardiff & Vale University Health Board.
	Christopher Beadle	Head of Health, Safety & Fire	• I act as a private Health and Safety Consultant outside of my hours with the Cwm Taf Morgannwg UHB.
Estates and Facilities			
	Tim Burns	Assistant Director of Planning (Capital & Estates)	• Wife works in the General Office at Ysbyty Cwm Rhondda.

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	Rose-Marie Cavill	Head of Capital	• Husband is Director at Boyes Rees Architects. • As I work in the Capital and Estates Department we deal with the appointment of design and construction staff, therefore when working my previous healthcare organisation which was declared. Husband does not work in the healthcare sector of the business and I would not get involved in the evaluation of any bid for any work that the company was involved in.
	Ian Phillips	Senior Project Manager	• This is my second term of office as a Governor. I have stepped down as Vice Chair requiring greater time input. • I am Governor at the Bishop of Llandaff High School in Cardiff, the only possible conflict is time to attend Governors' meetings. This is almost always in own time in the evenings and only occasionally in work time, is agreed in advance with my manager and sometimes taken as annual leave. I will be stepping down at the end of this academic year July 2019.
	Wayne Goodfield	Head of Clinical Engineer	• Brother works in Huntleigh Diagnostics Cardiff in Research & Development/Project Manager.

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	Kirk Riordan	Senior Project Manager	• My brother is a partner in James & Nicholas LLP – Architects & Engineers who the Health Board use to provide Consultancy Services on Capital projects.
	Tara Niccola Fildes-Jackson	Senior Projects Officer – Capital Planning	• Partner Philip Fildes-Bowen works for FlaktGroup UK as an Operational and Service Contracts Manager. Due to the nature of his business it could be considered that I would have a relevant interest if his company is used for CTMUHB works in which I may be partly to by association in my current position.
Finance & Procurement Department			
	Huw Evans	Deputy COO	• Spouse/Partner works for Welsh Assembly Government in the European transition department.
	Elisabeth Williams	Finance Manager (Capital)	• Director in Husband's company CPM21 Ltd. No transactions between UHB & CPM21 Ltd.
	Donna Marie White	Finance Manager	• Spouse employed as an Advanced Nurse Practitioner in Prince Charles Hospital.
	Daxa Varsani	Financial Accountant	• Director - VARSANIKESHRA LTD. Director - Legends(Cardiff) Limited • 25% ordinary share capital in a private limited company (rental property)- Varsanikeshra Ltd

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			• Volunteer member of Finance and General Purpose committee - Institute of Welsh Affairs • Independent Member - Audit and Risk Committee - Social Care Wales
General Surgery, Trauma & Orthopaedics and Urology Directorate			
	Rakesh Kumar	Consultant in Trauma & Orthopaedics	• Spouse/partner Co-director of company. • The company receives income from medical reports (personal injuries)- Medicolegal reporting. • Director of company R.Kumar Ltd.
	Sheila Jones	CNS Stoma Care	• All nursing and administrative posts, IT equipment, training in stoma care department, RGH are sponsored by Coloplast Ltd.
	Judith Murray	Consultant in Trauma & Orthopaedics	• Employed by Ministry of Justice Medical Appeal Tribunal Judge sitting in Cardiff
	Michael Rocker	Consultant Vascular Surgeon	• Director, Litfield House Medical Centre Limited, 1 Litfield Place, Clifton, Bristol BS8 3LS. Litfield House has private consulting rooms and a treatment suite. I carry out private practice there. I was asked to accept a position as director in case any surgical advice was required. There is no remuneration and I take no part in the day to day running.

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	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
	Stephen Sarasin	Consultant Orthopaedic Surgeon	• Private Practice Spire Hospital, Cardiff • Director of private limited company Stephen Sarasin Ltd., related to private practice and medicolegal services only. • Medico -legal practice based from Spire Hospital, Cardiff.
	Kevin Conway	Consultant Surgeon	• Wife acts as my private secretary. • Surgical editor for the British Medical Journal's On Examination online resource. • Private practice performed through the Nuffield Vale Hospital.
	Stuart Roy	Consultant Orthopaedic Surgery	• Receives consultancy fees from FH UK for work involved the TLS ACL system I use Practicing privileges at Spire hospital, Cardiff since 2005.
	David Morgan	Consultant in Trauma & Orthopaedics	• Medico-legal practice at Spire Hospital Cardiff • Partner in Cardiff Sports Orthopaedics LLP. • Director Morgan Medical Limited private company.
	Rachel Frost	Consultant Paediatrician	• Sponsorship to attend meeting in London November 2018. • Shire sponsorship of educational events. • Speaker at meeting arranged by Mead Johnson on cow's milk protein allergy.

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			• Sponsorship by Dermol for educational event provided to health visitors
	Puthucode N Haray	Consultant Surgeon	• Director of PN Haray Ltd.
	Alan Woodward	Consultant	• Undertakes private practice as a limited company.
	Daniel Lewis	Consultant in Orthopaedics	• Receives payments from Microport Orthopaedics to teach other surgeons. Royal Glamorgan Hospital is a recognised visitation centre for other orthopaedic surgeons to visit and be taught by myself. • Carries out private practice orthopaedic surgery at Spire Cardiff Hospital.
	Awen Iorwerth	Consultant in Trauma & Orthopaedics	• Board of Welsh Language in Health and Social Care. • Member of the board which comprises 3 days a year of board meetings at WAG Cathays Park. • Senior Clinical lecture School of Medicine, University of Cardiff.
	Timothy D Owen	Consultant Orthopaedic Surgeon	• Private Practice at Spire Cardiff Hospital and the Vale Nuffield Hospital. NHS waiting list initiative work Emerson's Green Treatment Centre Bristol.
	Timson Appanna	Consultant Urologist	• Private Practice at Nuffield and Vale

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Head & Neck Directorate			
	Samuel Fishpool	ENT Consultant	Director - Oxford Medical Innovations Ltd.
	Shakir F Mustafa	Consultant Oral & Maxillofacial Surgeon	• Working closely with Renishaw as part of an NHS UHB / Industry and academic community collaborative for research and quality assurance purposes. The health board gets a preferential rate (discounted) and priority service. No personal, or professional benefits to declare. • Chair of the Welsh Orthognathic Study Group an all Wales study group convening twice a year to for educational, research and quality improvement purposes. sponsored by DePuy Synthes on an bi-annual basis. No personal or professional benefit to declare • Course sponsorship and fee voucher. This is a sought after course and I have secured a sponsorship for the course fee (one of 2 UK places) by Johnson & Johnson. They provided an electronic voucher for the course fees and no other assistance is requested or granted. I have declared it to my DM and COO and

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			all the paperwork has been filled and sent through.
	James Ban	Consultant in Restorative Dentistry	• Director of business that provides dental care – in the process of arranging to become a dentist working 1 day a week in dental practice. Wife is also a director of this company, and is a dentist in practice for 05-1 day a week.
	Raina Goyal	Consultant Ophthalmologist	• Part owner of Dr Goyal private company. Secretary for the company and do not think it has any conflict of interest with this health board.
	Amit Gaur	Consultant Ophthalmologist	• Private Practice Privileges at Nuffield and Vale Hospitals. • Private Practice Privileges at Spire Hospital, Cardiff. • Sponsorship to attend CPD Meeting by Bayer.
	Pamela Stephenson	Consultant Orthodontist	• Spouse/Partner - Scientific Advisor for Dolphin software. • NHS Specialist practice in sessions not employed by Cwm Taf
	Raina Goyal	Consultant Ophthalmologist	• I am a part owner of Dr Goyal private company. I am secretary for the company and do

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			not think it has any conflict of interest with this health board.
	Ankur Das	Consultant	• I have a small private practice in ophthalmology including doing cases at the Vale Nuffield and local optometrists.
	Mohammed Muhtaseb	Consultant Ophthalmologist	• Spouse/Partner employed in my private practice. • Private medical practice. Limited company named iLase Ltd. • Muhtaseb Medical Ltd. • Digital Surgical Solutions Ltd.
Localities Directorate			
	David Miller	Primary Care Localities Clinical Director	• A member of a prospective partnership of 8 local GPs who are preparing to submit a bid for the award of a contact from Cwm Taf UHB for part of the Urgent Primary Care (previously known as out of hours) contract for Merthyr and Cynon at weekends. To date I have attended a pre-tender engagement meeting. The time line is for the application to be submitted in early June 2019 for an award and commencement of service in September 2019. I have declared this verbally at Primary Care CBM and will do at other relevant committees I attend.

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	Gareth John Jordan	Clinical Director Cynon Locality	• Former GP partner Aberaman and Foundary Town Clinic Aberdare active partnership finished 28/4/2019
	Ceri Wilson	Senior Nurse	• Husband works for Cwm Taf UHB.
Medicine Directorate			
	Suzanne Scott-Smith	Head of Medicines Management	• Chair of Royal Pharmaceutical Society Welsh Pharmacy Board. • Director of Coedrath Caravan Park (unpaid appointment).
	Andrew Aldridge	Pharmacist	• Wife works in pharmacy.
	Sophie Haddon	Pharmacist	• Spouse/partner - Doctor (surgical training). Currently on 6 month rotation in RGH as part of CT2 general surgery training.
	Rowena Havard	Formulary Pharmacist	• Spouse is a Surgeon at the Royal Glamorgan Hospital.
	Hannah Jameson	Clinical Pharmacist	• Husband is a porter at Royal Glamorgan Hospital.
	Louise Manousos	Prescribing Advisor	• Ad hoc locum pharmacist in Beacon Pharmacy, Merthyr Tydfil
	Helen Davies	Pharmacist	• I never attended the following conference as was on leave following a bereavement. Attending an industry funded educational conference in Berlin between 28/9/17 and 1/10/17. Funded by BMS/Pfizer.

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			• Delivered an evening educational session for cluster pharmacists on April 19th 2018 with honorarium from BMS/pfizer. • Attended a masterclass on the advancement of VTE treatments in London on 4th May. Funded by Pfizer/BMS. • Due to attend Barcelona for a cardiology and haematology conference on 22nd to 23rd June 2018, funded by Bayer. • Attended masterclass on anticoagulation in London. Funded by BMS/Pfizer. • Received honorarium from BMS/Pfizer for being expert speaker to clinical pharmacists educational evening (including dinner) from 7pm until 10pm. • Due to receive honorarium for being an expert speaker at an anticoagulation educational evening for pharmacists in the community setting.
	Sue Wooller	Pharmacist	• Paid a consultation fee by Daiichi Sankyo to collaborate with colleagues to produce a non-promotional educational presentation about anticoagulants for delivery to other centres across the UK. • Sponsored by Pfizer for travel and accommodation in London to attend a

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			Masterclass on Management of Venous Thromboembolism. • Overnight stay prior to all day conference • Fee paid by Bayer to Chair an educational meeting for Healthcare Professionals about anticoagulation for patients with Atrial Fibrillation
	Debbie Thomas	Prescribing Support Dietitian, Medicines Management, Bridgend	• Undertake a private clinical practice. • Advise patients in clinics which are held in the evenings and weekends. This does not interfere with NHS work for the Health Board
	Kate Spittle	Prescribing Lead Primary Care	• Practice Pharmacist, Practice 1 Keir Hardie. • Cardiff University - Pharmacy Undergraduate Placements - GP practices across Cardiff and Vale, Aneurin Bevan and Cwm Taf Health Boards. • GP Practice Pharmacist.
	Sasha Bettell-Higgins	Pharmacist	• Aethetics Company.
	Geraint Jones	Advanced Pharmacist HIV & Homecare	• Infrequently undertake community pharmacist locum work at stores within Cardiff & Vale, Cwm Taf Morgannwg & Aneurin Bevan University Health Boards.

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			• An accepted scholarship application to attend the European Workshop on Healthy Living with HIV 2019, hosted in Barcelona on September 13th & 14th 2019. The website noted Gilead as supplying major funding, with ViiV Healthcare being a 'gold level' sponsor and Janssen being a 'bronze level' sponsor. The website included the following statement: 'The sponsors have no input into the content of the materials and presentations used at this event.'
	Anthony Cadogan		• Spouse is a Consultant Physician at Cardiff and Vale UHB. • Personal Tutor for Cardiff University Independent Prescribing Course
	Rhianydd Nash	Pharmacist Mental Health	• Aesthetics. • Locum Pharmacist- Tesco
	Edward Matthews	Pharmacist	• Wife works as a Pharmacist
	Ffion Hawkins	Pharmacist Educational & Training/Medicine	• Updated pre-registration pharmacist training material for WCPPE and HEIW on medicines management and patient counselling & consultation skills (2018/19).

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			Conducted respiratory workshops for WCPEE in 2018 for pre-registration pharmacists, and due to hold respiratory workshops Winter 2019 for HEIW aimed at pre-registration pharmacists
	Alison Jones	Community Pharmacist Facilitator	• Ad-hoc community pharmacy locum within CTMUHB.
	Catrin Walters	Pharmacist	• Partner is a Radiology Registrar, but does not in Cwm Taf Morgannwg Health Board. • Will be delivering four paid training sessions in this financial year to pre-registration pharmacists on enquiry answering skills in collaboration with HEIW. I will be doing this in my own time (annual leave).
	James Anthony Jenkins	Prescribing Advisor	• Director/Owner J3 Windows Ltd CF44 6DA
	Kathryn Howard	Team Leader Medicines, Governance & MMPU	• Independent Prescribing Tutor for Cardiff University. • This work is carried out in my own time. I receive payment for each student I tutor
	Ian Darwin	Pharmacist	• Board member of Tamareneh Rhondda.

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			• A charity to to raise funds and supply donated equipment to improve the lives of the inhabitants of Sierra Leone.
Mental Health Directorate			
	Lesa S Wright	Consultant Psychiatrist	• Director, TwynBrain Ltd. Health Technology. • Mental health court reports.
	Paul D Davies	Assistant Director	Daughter is Ward Manager of PICU (Mental Health) within Cwm Taf UHB. • I am a Research Fellow at the University of South Wales.
	Chandrashekar Basavaraj	Locum Consultant Psychiatrist	• Private practice via my limited company CB Medicals. Seeing private patients given by two companies Summerfield Healthcare and Mental Health and well-being services in England.
	Robert Richards	Senior Nurse	• Private practice as Aesthetics Practitioner and prescriber.
	Mridul Biswas	Consultant	• Partner works for the Health Board.
	Catrin McGuire	Clinical Psychologist	• Providing monthly private CBT supervision. When required, providing private 1-1 CBT.
	Phillip Lewis	Head of Mental Health Nursing	• Wife works in Mental Health Directorate.
	Rachel Akande	Consultant Clinical Psychologist	• I have a small private practice as a Clinical Psychologist. I offer individuals

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			psychological therapy out of consulting rooms in Cardiff. • Submitted proposals to offer training to Psychiatrist trainees via MRC Psych • I am a course tutor on the South Wales Cognitive Analysis Therapy Practitioner training
	Malin Falck	Consultant Clinical Neuropsychologist	• Private work approximately 2 hours per week on average
	Pravir Shanker Prasad	Consultant Psychiatrist (POW)	• My wife works as associate Specialist in Anaesthesia in Prince Charles Hospital • Consulting Psychiatrist at Bridgend Private Clinic where I get referrals from private individuals/GPs/organisations including insurance agencies • Consulting Psychiatrist Priory Group
	Sue Gwyn	Service Manager Mental Health (POW)	• NMC panel member • Former trustee of Brynawel rehab until June 2019. Now resigned from board
	Phillip Brawn	Senior Clinical Psychologist	• I have in the past offered occasional private clinical psychology sessions. I may be offered further private work psychology sessions on an ad hoc basis. These will not be clients currently living in

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			the CTMUHB catchment area or being seen by CTMUHB mental health services • I see these clients in the evening out of contracted cwm taf uhb hours and not on CTMHB property
Obstetrics & Gynaecology and Sexual Health Directorate			
	Sean Watermeyer	Consultant in Obstetrics & Gynaecology	• Mrs Alison Watermeyer - secretary of my company SABGE. SABGE formed as a private company of which I am a director as part of my private practice • I carry out private work at CRGW (Ely Meadows) which is a fertility clinic - through SABGE. • Carry out private work at the Vale Hospital, Hensol - through SABGE. • Written book "Infertility, IVF and Miscarriage" published by Parthian publishers.
	Adel Abdullah	Consultant in GUM	• Fortnightly clinic at spire hospital Cardiff. I applied for financial assistance from Gilead to complement what I get from the trust to attend the BASHH conference 2 years ago. The medical directorate had been informed and are aware of it.

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	Sreevidya Govindapillai Ambika	Consultant Obstetrician & Gynaecologist	• Invitation from Olympus to attend one day live TLH course in Derby Hospital to be held in 29th April 2019.
	Gareth MacGillivray	Consultant Urologist	• I undertake private work outside of my NHS sessions.
	Hatel Tejura	Consultant	• Both wife and I are directors in an infertility company.
	Sharon Vine	Team Manager Support Senior Nurse	• Husband works for Cwm Taf UHB.
	Lucy Jones	Associate Specialist in Sexual Health Clinical Lecturer	• Clinical lecturer at Cardiff University. • Private practice in sexual health/director. • Director of company for consulting room hire for private medical consultations. Not on NHS sites. • Secretary for British Association of sexual health and HIV, Wales. • Member of expert advisory panel to Public Health Wales on public health outcomes framework.
	Melissa Claire Cutlan	Team Leader, GDUA/EPU	• Member of clinical panel at Huntleigh Diagnostics giving advice on development of equipment.
	Nadia Bhal	Consultant Obstetrician & Gynaecologist.	• Spouse/Partner - Director of Infiniti Healthcare (Private clinic). • Co-director of Infiniti healthcare.

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	Sanjay Chawathe	Consultant Obstetrician & Gynaecologist	• Private practice of Gynaecology at Nuffield Cardiff Hospital.
	Steven Vine	Consultant Obstetrician & Gynaecologist	• Private practice in Spire Hospital, Cardiff
Operational Management			
	Kath McGrath	Deputy COO	• Daughter works within the UHB in a senior nurse role
	Dawn Casey	MacMillan Lead Nurse Cancer Services	• Spouse/Partner works for Welsh Assembly Government in the European Transition Department
	Amanda Powell	Directorate Manager, Acute Medicine, A&E Medical Records and Out Patients	• Volunteer at Beddau & Tynant Community Library.
Pathology Directorate			
	Iman Sabet	Consultant Haematology	• I have been invited, as a delegate in an educational meeting for 2 days . This was arranged by Bayer pharmaceutical companies.
	Helen Archer	Microbiology Service Manager	• Husband works in HR in Cwm Taf.
	Richard Davies	Blood Sciences Site Manager	• My wife works in the same department.
	Kelly Mitchem	Consultant Clinical Biochemist	• Undertake Consultant Clinical Biochemist duties/services for Synlab Laboratory Services, Abergavenny. Involves providing clinical advice and information when

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			required, reviewing SOP's and abnormal EQA and assistance in training staff. Approximately 1-2 hour/week (undertaken in own time).
	Elizabeth Husband	Consultant Histopathologist	• Have joined SYNPATH LIMITED (Company No 04666166) Role: Director. Activity: Cremation form 5 completion & private surgical pathology specimens (CTUHB)
	Joanne C Roche	Consultant Histopathologist	• Spouse/partner: Share holder Synpath Ltd. • Director of Synpath Ltd.
	Esther Youd	Consultant Histopathologist	• My husband is a shareholder in Synpath Ltd (see below):- • Director of Synpath Ltd which is a registered company used by myself and colleagues to receive Category II and non-NHS income. The accountancy is provided by Carston Accountants. • I am Assistant Registrar and Trustee of the Royal College of Pathologists. • I am Chair of the Academy of Medical Royal Colleges in Wales.
	Phillip Brumwell	Consultant Pathologist	• Wife is a shareholder in Synpath Ltd. (see below).

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			• Director of Synpath Ltd which is a registered company used by myself and colleagues to receive Category II and non-NHS (private) income. The accountancy is provided by Carston Accountants.
	Brian Tennant	Principal Clinical Scientist	• Member of Association for Clinical Biochemistry and Laboratory Medicine (ACB) Wales regional committee (Ordinary member)
Patient Safety and Care Directorate			
	Rebecca Thomas	Senior Nurse Professional Standards and Quality improvement	• Board member Cwm Taf Care and Repair
			•
Primary Care Directorate			
	Craige Wilson	Assistant Director Primary Care Children & Community Services	• Wife works as a Senior Nurse, @ Home Service.
	Caroline James	Pharmacist – Managed Practice	• I also work for Cardiff and Vale UHB • I work in a GP surgery in Cardiff • I do locum cover for various community pharmacies in Wales
	Tammie Sook Peng Ng	Primary Care Advanced Pharmacist	• My husband works at the School of Pharmacy, Swansea University.

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Radiology Directorate			
	Sally Bolt	Consultant Radiologist	• My husband works for CTUHB also is a consultant physician. I don't think this is a conflict. • Director of Bolt Healthcare, which I use to manage my work in the private sector at Spire Hospital, Cardiff. This does not relate to my work for the health board.
	Christopher Kalinka	Head of Radiography	• UK council member, for Wales, society of Radiographers - trade union board member, non-executive director. • Vice president Society of Radiographers. • College board of trustees member of board - charity education radiography based.
	Gavin Clague	Consultant Radiologist	• Private practice undertaken at: Spire Hospital, Cardiff Cobalt Imaging, Cheltenham • Private practice undertaken at: European Scanning Centre, Cardiff. • RCR representative on National Low Back Pain clinical group. • Private practice undertaken at Nuffield Hospital, Cardiff.
	Nidhi Jain	Consultant Radiologist	• Reporting scans at Cobalt Health (at Welsh Institute of Chiropractors), a registered charity.

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	Phillip Wardle	Consultant Radiologist	• Wife is a partner in Wardle Consulting Partnership. Manages all income outside of NHS Work. My involvement is entirely related to COBALT MRI reporting and Vale Healthcare Radiologist. • COBALT MRI reporting. • Vale Healthcare Radiologist. • Wardle Consulting Partnership. Manages all income outside of NHS work - my involvement is entirely related to entries 1 and 2.
	Shaun Halpin	Consultant Neuro-radiologist	• Medical Director, DMC Healthcare Radiology Reporting Ltd
	Royston Hibberd	Superintendent Radiographer	• Work in private practice (Spire and Nuffield).
Therapies Directorate			
	Andrew Murphy	Physiotherapist	• Taking part in the "Help You Help Yourself" programme run by the BLF in Merthyr Tydfil Leisure Centre.
	Stuart Andrew	Podiatrist	• Private podiatry work one evening a week for a Health clinic in Talbot Green.
	Leah Litchfiled	Podiatrist	• Husband works as a podiatrist in the department.
	Jacqueline Jones-Thomas	Podiatrist	• Private work, unsure of exact date but have been doing it for a few years.

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	Annmarie Hancock	Podiatrist	• I on occasions do some private nail cutting but not on a regular basis.
	Margaret Manton	Physiotherapist Professional Manager Acute	• My mother-in-law is employed by CTUHB as Band 6 Speech and Language therapist. • Clinically I am a paediatric physiotherapist and see an adult private patient with Cerebral Palsy on Wednesday evenings. This patient was never on my caseload within paediatrics and had transitioned to adult services when I started my post so there was no crossover or conflict of interest. • Private physiotherapy on an ad-hoc basis
	Christine Dowle	Deputy Head of Service SLT	• Trustee of Royal College of Speech and Language Therapists.
	Natalie Potter	Macmillan Dietetian/Acting up Head of Audit for Dietetics	• Husband works for company associated with Nutritional products Fresenius kabi. • Occasionally I undertake paid work lecturing at Cardiff metropolitan University in my own time on days I am not working for Cwm Taf UHB.
	Gafin Morgan	ESP Podiatrist	• Private Practice 1 evening per week irregular.

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	Owen Pearce	MSK Clinical Lead Podiatrist	• Wife works in Community Podiatry Team in Cwm Taf UHB. • Private practice in Podiatry.
	Helen Welch	Principle Physiotherapist – Clinical Lead CMATS	• Vice Chair MACP Professional network group of CSP
	Keri Hutchinson	Podiatrist	• Ad-hoc Part Time Lecturing at Cardiff Met University.
	Jacqueline Jones-Thomas	Podiatrist	• Husband is Director of Culture, Sport and Tourism for Welsh Government and is non-executive on the Welsh Government's Health and Social Service Group's Audit and Risk Assurance Committee. • Private work, unsure of exact date but have been doing it for a few years.
	Hayley Davies	Physiotherapy Professional Manager	• Occasional private work as a reflexologist/aromatherapist.
	Debbie Thomas	Prescribing Support Dietitian (Glanrhyd)	• I run a private practice and do this work on some evenings and weekends. It does not interfere with my NHS work. • My private practice offers advice on the dietary treatment of IBS.
	Cerydd Muller	Occupational Therapist	• Volunteer within Girl guiding, outside of working hours
	Donna Peters	OT Technician	• Head of Mental Health Nursing

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	Nia Gill	Podiatrist	• Husband also works as podiatrist for Cwm Taf. • Private podiatry work.
	Sarah Howells	Occupational Therapy Technician	• Spouse started working for UHB July 2018 -Porter. Duration of interest 30 years. • Stepson x 1 – Porter • Stepson x 2 – Radiology Assistant • Step-son x 1 fiancée - Staff nurse • Brother-in-law x 1 – Porter • Sister-in-law - CPU Manager • Nephew - Catering assistant • Niece - Cardio Physiologist
	Helen Welch	Principle Physiotherapist/Clinical Lead CMATS	• Vice Chair MACP Professional network group of CSP
	Kathryn Head	Clinical Lead Speech & Language Therapist	• I undertake occasional private speech and language therapy on an adhoc basis for communication in adults. This is limited to 3 hours maximum per week and typically occurs on a Sunday. I ensure that clients seen don't reside and are not in receipt of

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			services within the Cwm Taf Morganwyg UHB locality.
	Kerry Hopkins	OT Technician	• Spouse/Partner - Apex Medical. • Invercare • Senior Matron in POW
	Joanne Hollyman	OT Technician	• Cover Bank Shifts with Cwm Taf Morgannwg on rest day. 2-3 shifts per month.
	Kate Stubbs	Occupational Therapist	• Partner(since September 2016) is a FY2 Dr in PCH, rotating through Peadiatrics, T&O and A&E due to start in Health board 7/8/19 from Aneurin Bevan. • Partner - Living together since June 26th 2018.
	Elizabeth Strudwick	Occupational Therapist	• Trustee Central Beacons Mountain Rescue. • Secretary of Troedyrhiw Scout Group
	Sarah Hughes	Principal Speech and Language Therapist	• Secretary, Mango Planning and Development Ltd • Director, Have Your Say Ltd • Director, Narra Consulting Limited

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	Matt Bowen	Principal OT	• Private advisory work start-up. Currently not active but may reinitiate in forthcoming year
	Rebecca Down	Assistant Therapy Practitioner	• Mother is a staff nurse
Workforce & Organisational Development			
	Karen Vaughan	Occupational Health & Wellbeing manager	• I have recently set up a website to promote my freelance work as a dietitian, seeing clients with Irritable Bowel Syndrome and advising on the FODMAP diet. I have not yet seen any clients, but hopefully soon. • Freelance dietetic work, clients will be seen outside of working hours. Potential conflict if members of Cwm Taf (CT) staff seek my input via my private work and I also manage the staff Occupational Health and Wellbeing service. However, in my CT role I do not see employees on a clinical basis and role is limited to clinical management only.
	Nicholas Price	Senior HR Manager	• I am a non-stipendiary assistant priest at St Nicholas' Greek Orthodox Church, Cardiff. Although I do not receive a salary, I am given travel expenses.

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	Greg McKenzie	Staff Nurse	• I am part of a registered private Business"OSCE Smart Skills" on the 22/08/19. The company will be training oversees nurses and potentially upskilling other staff. All involvement will be delivered outside my contracted hours and will have no impact on my ability to perform my work (as per guidance).. It will not involve the use of any confidential information related to Cwm Taf UHB
	Abbey Griffiths	Practice Development Nurse	• I am part of a registered private Business"OSCE Smart Skills" on the 22/08/19. The company will be training oversees nurses and potentially upskilling other staff. All involvement will be delivered outside my contracted hours and will have no impact on my ability to perform my work (as per guidance).. It will not involve the use of any confidential information related to Cwm Taf UHB
HOSTED BODIES			
	Anthony Hayward	Assistant Director of National Collaborative Commissioning Unit	• Appointment of Justice of the Peace.

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	Julian Baker	Director of National Collaborative Commissioning Unit	• Member of the NHS Benchmarking Network (NHSBN) Steering Group. • Honorary Research Fellow, Swansea University, College of Human & Health Sciences

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
26468878	Dr	LI	Luis	Macchiavello	110 ACT Directorate	110 PCH Specialty Anaesthetics	Consultant	N
10644864	Dr	M	Madhwapathi	Sudhakar	110 ACT Directorate	110 PCH Specialty Anaesthetics	Consultant	N
21907927	Dr	DH	David	Davis	110 ACT Directorate	110 RGH Medical Staff - Anaesthetics	Consultant	N
26327079	Dr	C	Ceri	Lynch	110 ACT Directorate	110 RGH Medical Staff - Anaesthetics	Consultant	N
25053945	Dr	JV	Jayaprakash	Singh	110 ACT Directorate	110 RGH Medical Staff - Anaesthetics	Consultant	N
24022976-2	Dr	TC	Thomas	Bird	110 ACT Directorate	110 RGH Medical Staff - Anaesthetics	Consultant	N
27686214	Dr	R	Robert	Davies	110 ACT Directorate	110 RGH Medical Staff - Anaesthetics	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
22123187	Mrs.	K	Kelly	Downes	110 Acute Medicine and A&E D	110 PCH Directorate Management Medicine	Nurse Manager	N
10652256	Mrs.	MP	Marnie	Lake	110 Acute Medicine and A&E D	110 RGH Directorate Office - Acute Medicine and	Senior Manager	N
23221112	Mrs.	C	Caren	Hobrough-Harr	110 Acute Medicine and A&E D	110 RGH Pacing Service - Medicine	Manager	N
10652771	Mrs.	L	Lisa	Deering	110 Acute Medicine and A&E D	110 RGH Endoscopy Clinic - Medicine	Sister/Charge Nurse	N
10653829	Dr	M	Mohamed	Hassan	110 Acute Medicine and A&E D	110 PCH Specialty - Acute Medicine	Consultant	N
24425484	Dr	AG	Aled	Huws	110 Acute Medicine and A&E D	110 PCH Specialty - Acute Medicine	Consultant	N
23429035	Mr.	MW	Mark	Stephens	110 Acute Medicine and A&E D	110 PCH Specialty - Acute Medicine	Consultant	N
23275598	Dr	S	Susan	Nolan	110 Acute Medicine and A&E D	110 PCH Specialty - Cardiology	Consultant	N
10655294	Dr	P	Piero	Baglioni	110 Acute Medicine and A&E D	110 PCH Specialty - Diabetes	Consultant	N
26025096-2	Dr	AE	Alex	Brown	110 Acute Medicine and A&E D	110 PCH Specialty - Diabetes	Consultant	N
20744503	Dr	OE	Onyebuchi	Okosieme	110 Acute Medicine and A&E D	110 PCH Specialty - Diabetes	Consultant	N
26216974-2	Dr	JJ	Jonathan	Barlow	110 Acute Medicine and A&E D	110 PCH Specialty - Gastroenterology	Consultant	N
22320233	Dr	SH	Sherouk	El-Batrawy	110 Acute Medicine and A&E D	110 PCH Specialty - Respiratory	Consultant	N
10644679	Mr.	M	Michael	Obiako	110 Acute Medicine and A&E D	110 PCH Specialty A&E	Consultant	N
10647597	Dr	C	Christian	Aldridge	110 Acute Medicine and A&E D	110 PCH Specialty Dermatology	Consultant	N
24706025	Dr	SA	Shibeb	Al-Mudhaffer	110 Acute Medicine and A&E D	110 PCH Specialty Rheumatology	Consultant	N
26229463	Dr	AM	Anna	Lewis	110 Acute Medicine and A&E D	110 RGH Medical Staff - Acute Medicine	Consultant	N
10648634	Dr	GR	Gethin	Ellis	110 Acute Medicine and A&E D	110 RGH Medical Staff - Cardiology	Consultant	N
10652086	Dr	HA	Helen	Lane	110 Acute Medicine and A&E D	110 RGH Medical Staff - Diabetes	Consultant	N
20149410	Dr	PJ	Penelope	Owen	110 Acute Medicine and A&E D	110 RGH Medical Staff - Diabetes	Consultant	N
10650275	Dr	ND	Neil	Hawkes	110 Acute Medicine and A&E D	110 RGH Medical Staff - Gastroenterology	Consultant	N
10650955	Dr	C	Ceril	Rhys-Dillon	110 Acute Medicine and A&E D	110 RGH Medical Staff - Rheumatology	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
25767724	Mrs.	KA	Kathryn	Evans	110 CAMHS Network Directorate	110 CAMHS ABMU - Therapies	High Intensity Therapist	N
20159903	Miss	KV	Karen	McIntosh	110 CAMHS Network Directorate	110 CAMHS Cwm Taf - Nursing	Sister/Charge Nurse	N
10665341-2	Mrs.	OE	Olwen	Jeffs	110 CAMHS Network Directorate	110 CAMHS Cwm Taf - Therapies	Clinical Psychologist	N
27254941	Dr	JD	Jonathan	Williams	110 CAMHS Network Directorate	110 CAMHS FACT	Clinical Psychologist	N
20228043	Ms.	CC	Cheryl	Walters	110 CAMHS Network Directorate	110 CAMHS Tier 4 - Nursing	Nurse Manager	N
10653135-2	Mrs.	SA	Sarah	Mordecai	110 CAMHS Network Directorate	110 CAMHS Eating Disorders	Nurse Manager	N
27094446	Mr.	MJ	Mark	Rivett	110 CAMHS Network Directorate	110 CAMHS Eating Disorders	Clinical Psychologist	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
21908137	Mr.	GJ	Glenn	Clewer	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 PCH Specialty T&O	Consultant	N
10645104	Mr.	K	Kyriakos	Karras	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 PCH Specialty T&O	Consultant	N
21604589	Mr.	PM	Peter	Lewis	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 PCH Specialty T&O	Consultant	N
10647757	Dr	TJ	Timothy	Havard	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - General Surgery	Consultant	N
10647784	Mr.	E	Eifion	Vaughan-Willia	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - General Surgery	Consultant	N
21908197	Dr	MF	Maged	Farag	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - General Surgery	Consultant	N
10647527	Mr.	JP	Jonathan	Davies	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - T&O	Consultant	N
10658727	Dr	DJ	David	Pemberton	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - T&O	Consultant	N
10651135	Mr.	TC	rachel	Appanna	110 General Surgery, Trauma & Orthopaedics and Urology Directorate	110 RGH Medical Staff - Urology	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10660022	Dr	HO	Huw	Williams	110 Head & Neck Directorate	110 RGH Medical Staff - ENT	Consultant	N
26491581	Mr.	A	Aji	Raghuram	110 Head & Neck Directorate	110 RGH Medical Staff - Ophthalmology	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10644533	Mr.	LP	Liam	Morrissey	110 ICT Directorate	110 Information Communication Technology Dept	Senior Manager	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
22749401	Mrs.	C	Caroline	Craven	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
26074521	Mrs.	AC	Alison	Davies	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
23995596	Miss	JF	Jenny Sau	Ng	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
21595423	Mrs.	L	Lorna	Phillips	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
26183176	Mrs.	CJ	Carolyn	Poulter	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
26732150	Mrs.	J	Joanne	Reid	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
10648331-2	Ms.	A	Adele	Sepahpour	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
10584098	Mrs.	EJ	Emma	Hinks	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
10579738	Dr	B	Brian	Hawkins	110 Medicines Management Di	110 Primary Care Prescribing Team	Pharmacist	N
10644638	Miss	LW	Lisa	Dafydd	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
27448417	Mrs.	SR	Santosh	Datla	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
10645217	Mrs.	CF	Ceri	Derrick	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
20905542	Mrs.	JS	Jenni	Hathway	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
21033518	Mr.	OM	Owain	Jones	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
10653207	Mrs.	JL	Joanne	Pritchard	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
26084494	Mr.	RM	Rhys	Williams	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
21902917	Mr.	GP	Gareth	Tyrrell	110 Medicines Management Di	110 RGH Pharmacy	Pharmacist	N
10646004	Miss	C	Caroline	Browne	110 Medicines Management Di	110 RGH Pharmacy - NLIAH funded	Pharmacist	N
26113211	Ms.	HL	Hannah	Wilton	110 Medicines Management Di	110 RGH Pharmacy - NLIAH funded	Pharmacist	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
26012651	Dr	S	Stella	Swift	110 Mental Health Directorate	110 Adult - Psychology	Clinical Psychologist	N
23743022	Dr	E	Elanor	Maybury	110 Mental Health Directorate	110 Adult - Psychology	Clinical Psychologist	N
10649530	Mrs.	A	Ann	Orrells	110 Mental Health Directorate	110 EMI - Management & Administration	Nurse Manager	N
10644580	Mr.	RM	Rhodri	Abraham	110 Mental Health Directorate	110 Rehabilitation - Management & Administrat	Community Practitioner	N
10655529	Dr	KT	Kishore	Kale	110 Mental Health Directorate	110 Adult - Medical Staff	Consultant	N
26883591	Dr	CG	Ceri	Evans	110 Mental Health Directorate	110 EMI - Medical Staff	Consultant	N
26838020	Dr	PM	Priyadarshini	Rangappagowd	110 Mental Health Directorate	110 EMI - Medical Staff	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10647366	Mrs.	CM	Caroline	Robertson-Cow	110 Obstetrics & Gynaecology a	110 RGH Womens Health Unit	Advanced Practitioner	N
10643306-3	Mrs.	P	Patricia	Chan	110 Obstetrics & Gynaecology a	110 Midwife Practitioners	Midwife - Specialist Practitioner	N
27178545-2	Mrs.	EM	Elizabeth	Davies	110 Obstetrics & Gynaecology a	110 RGH Acute Midwifery & Nursing	Midwife - Consultant	N
20591095-2	Dr	HG	Helen	Bayliss	110 Obstetrics & Gynaecology a	110 PCH Specialty Obstetrics & Gynaecology	Consultant	N
20770991	Dr	SA	Suhashini	Sivasuriam	110 Obstetrics & Gynaecology a	110 PCH Specialty Obstetrics & Gynaecology	Consultant	N
25073325	Dr	N	Narasimha	Swamy	110 Obstetrics & Gynaecology a	110 RGH Medical Staff - Obs & Gynae	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10648780	Mrs.	DS	Deborah	Matthews	110 Operations Management D	110 RGH Acute Division Management	Nurse Manager	N
23360104	Miss	DJ	Debbie	Evans	110 Operations Management D	110 RGH Acute Division Management	Senior Manager	N
10645773	Miss	R	Rhian	Beynon	110 Operations Management D	110 Research & Development	Senior Manager	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10648930	Dr	GJ	Gareth	David	110 Paediatrics Acute & Comm	110 PCH Directorate Management Paediatrics	Clinical Psychologist	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
21138601	Dr	WY	Wei	Wan	110 Pathology Directorate	110 PCH Specialty Pathology	Consultant	N
27496838	Dr	H	Hanadi	Ezmigna	110 Pathology Directorate	110 RGH Medical Staff - Pathology	Consultant	N
10651884	Dr	JL	Jason	Shannon	110 Pathology Directorate	110 RGH Medical Staff - Pathology	Consultant	N
26984211	Dr	A	Alexandra	Tsitsopoulou	110 Pathology Directorate	110 RGH Medical Staff - Pathology	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10579797	Mr.	DR	Darrell	Clarke	110 Planning and Partnership D	110 Planning Team	Senior Manager	N
10579657	Mrs.	SC	Samia	Saeed-Edmond	110 Planning and Partnership D	110 Planning Team	Senior Manager	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
25601743	Dr	RA	Rhodri	Davies	110 Radiology Directorate	110 PCH Specialty Radiology	Consultant	N
26751780-2	Dr	RM	Rowland	Dafydd	110 Radiology Directorate	110 RGH Medical Staff - Radiology	Consultant	N
21626109	Dr	B	Balan	Palaniappan	110 Radiology Directorate	110 RGH Medical Staff - Radiology	Consultant	N
10653581	Dr	EJ	Esther	Pollitt	110 Radiology Directorate	110 RGH Medical Staff - Radiology	Consultant	N
10648041	Dr	R	Rhian	Rhys	110 Radiology Directorate	110 RGH Medical Staff - Radiology	Consultant	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
10645922	Mrs.	SJ	Stacey	James	110 Therapies Directorate	110 Dietetics Dept	Dietitian	N
26585043-2	Miss	SM	Sian	Lewis	110 Therapies Directorate	110 Dietetics Dept	Dietitian	N
10657535	Mr.	RA	Richard	Lewis	110 Therapies Directorate	110 PCH Assistant Director of Therapies	Senior Manager	N

Assignment Nu	Title	Initials	First Name	Last Name	Org L4	Org L6	Role	Yes/no/left
26241053	Miss	CD	Ceri	Butler	110 Workforce & Organisationa	110 PCH Post Graduate	Senior Manager	N
25919039	Dr	LA	Lesley	Jones	110 Workforce & Organisationa	110 PCH Post Graduate	Senior Manager	N
10658551	Mr.	MS	Malcolm	Jones	110 Workforce & Organisationa	110 PCH Resuscitation Training	Technician	N
10649488	Mr.	ST	Stephen	James	110 Workforce & Organisationa	110 111 Project	Senior Manager	N
10648566	Miss	EM	Elizabeth	Jenkins	110 Workforce & Organisationa	110 Equality and Welsh Language	Senior Manager	N
10650429	Mr.	JA	James	Coglan	110 Workforce & Organisationa	110 Human Resources	Senior Manager	N
25145451	Mrs.	DM	Dena	Jones	110 Workforce & Organisationa	110 Human Resources	Senior Manager	N
20491634	Ms.	SE	Sara	Mason	110 Workforce & Organisationa	110 Human Resources	Senior Manager	N
27400456	Mrs.	PG	Phillippa	Doble	110 Workforce & Organisationa	110 Human Resources	Senior Manager	N
10656411	Mrs.	AS	Angela	Lloyd	110 Workforce & Organisationa	110 Human Resources	Senior Manager	N
10659963	Mr.	MC	Mark	Gibbs	110 Workforce & Organisationa	110 Learning and Development	Senior Manager	N
10659327	Mrs.	HM	Hilary	Hopkins	110 Workforce & Organisationa	110 Medical Personnel	Senior Manager	N
23461885	Mrs.	SM	Sarah	Francis	110 Workforce & Organisationa	110 NHS Jobs	Senior Manager	N
26678073	Mrs.	S	Suzanne	Vaughan	110 Workforce & Organisationa	110 Occupational Health	Nurse Manager	N
22746609	Mrs.	NS	Nicola	Thomas-Robert	110 Workforce & Organisationa	110 Organisational Development	Senior Manager	N
21460479	Miss	J	Joanne	Jamieson	110 Workforce & Organisationa	110 Policy and Compliance	Senior Manager	N
10653204-3	Ms.	B	Beth	Winder	110 Workforce & Organisationa	110 Workforce Information	Senior Manager	N

APPENDIX 5

CWM TAF MORGANWWG UNIVERSITY HEALTH BOARD

GIFTS, INDUCEMENT AND HOSPITALITY REGISTER JULY 2018 – OCTOBER 2019

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
423	Juan-Claudio Ferre Vidal	Consultant in Child & Adolescent Psychiatry	3/7/18	9.8.1 Commercial Sponsorship for Attendance at courses/conferences. Company paid for flights and accommodation for2 days in Berlin International Conference on ADHD	Flynn Pharma	Yes
424	Juan-Claudio Ferre Vidal	Consultant in Child & Adolescent Psychiatry	21/4/18	9.8.1 Commercial Sponsorship for attendance at courses/conference. Company paid for one night accommodation and conference in London they organised.	Shire	Yes
425	Juan-Claudio Ferre Vidal	Consultant in Child and Adolescent Psychiatry	23/3/18	9.8.1 Commercial sponsorship for attendance at courses/conference. Meeting of Minds Annual Conference. Company paid for 2 night's accommodation	Shire	

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
				and flights to an international conference they organised in the Hague.		
426	Dental Laboratory, Prince Charles Hospital	Anaesthetics, Critical Care, Theatres and Head & Neck	19/9/17 received 2019	Computer and 3D Scanner (DS30) loaned to the Dental Laboratory as part of the Framework Collaboration Agreement with Reinishaw plc	Renishaw plc, New Mills, Wotton-under-Edge, Gloucester, GL12 8JR	Accepted
427	Dr Rashmina Shrestha	CT3 Psychiatry	5/7/18	Pendant with necklace worth £15 from patient he was seeing for psychotherapy last session.	Patient	Accepted
428	MDTU Prince Charles Hospital	Reception Workforce & OD	27/7/18	£150 purchase of stand spec F1 Induction NO1 13042 Invoice 87039	BMA, 5th Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, CF10 4D0	Accepted
429	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	27/7/18	£150 Sponsorship of F1 Doctors Induction. NOT CT/12890. Invoice No. 87047	BMA, 5th Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ	Accepted
430	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	1/8/18	£150 Sponsorship of Junior Doctors	Bayer, 400 South Oak Way, Green Park, Reading, Berksire, RG2 6AD	Accepted
431	Medical Education	WOD Centre	1/8/18	£150 Sponsorship of	A Menarini, AMFI SRI.,	Accepted

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
	Centre, Royal Glamorgan Hospital	Receptionist		Junior Doctors Induction CT/13150	Menarini House, Mercury Park, Wycombe Lane, Woodburn Green, Buckinghamshire H10 0HH	
432	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	1/8/18	£150 Sponsorship at Junior Doctors induction	MSD Herford Road, Hoddesdon, Hertfordshire, EN11 9BU	Accepted
433	Tim Woods	Senior Assistant Audiologist, Head & Neck Dept	9/8/18	£10 cash. Patient insistent that the money be accepted. Head of Dept suggested that tea and coffee be bought for the department.	Patient	Accepted
434	Out Patients 2	All Staff, Sexual Health Dept	11/10/18	Chocolates	Patient	Accepted
435	Shakir F Mustafa	Consultant Oral Surgeon	18/10/18	Course Fee Sponsorship, no other expenses paid	Depuy Synthes, Johnson & Johnson Medical Ltd., St Anthony's Road, Beeston, Leeds, LS11 8DT	Accepted
436	Dom Rapley	Assistant Psychotherapist	24/12/18	1 Bottle of Moet et Chadon Imperial Champagne	Patient	Accepted
437	Manish Chebbi	Consultant Physician and Geriatrician	18/4/18	Attended training day on newer anticoagulants in stroke prevention at Birmingham. No	Sponsored by pharmaceutical company	Accepted

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
				accommodation or other benefit. Sponsored dinner and teaching on Atrial Fibrillation and Direct Anticoagulants. Role of Consultant speaker for Pfizer. Honorarium of £500 as a one off contract for the presentation.		
438	Rachel Frost	Consultant Paediatrician	13/3/18	Masterclass in asthma management, sponsored event covering overnight accommodation and educational meeting (2 days		Accepted
439	Iman Sabet	Consultant Haematology	14/5/18	Invited to attend as a delegate BSH with Jansen Pharmaceutical company for 3 days.	Jansen Pharmaceutical Company	Accepted
440	Kate Spittle	Lead Pharmacist Primary Care	12/6/18	Presentation at Conference, London. Presentation on Use of Opioids in Pain Managements in Primary Care		Accepted
441	David Miller	Locality Clinical Director	1/2/18	On occasions, accepted hospitality from	HJE Healthcare Accountants, Cardiff.	Accepted

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
				representatives of the pharmaceutical industry when attending educational events. Present when industry representatives have given promotional lunches food and drinks in GP practice. On occasions accepted hospitality from HJE Healthcare Accountants as a guest with provision of food and drinks at rugby matches.		
442	David Miller	Locality Clinical Director	1/1/18	Member of a group of 8 GPs known as the Out of Hours Independent Partnership. Group explores the potential for provision of Out of Hours Primary Care on a contract basis from Health Boards. This is only an early stage and there are no live contracts being tendered for at the	Out of Hours Independent Partnership	

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
				present time		
443	Darren Gill	Corporate Services Manual Handling Advisor	15/2/19	Tickets to Wales v Ireland Rugby match 16 March 2019	Adam Frost, Drive De Vilbiss Healthcare Ltd., Heathfield Lane, Birkenshaw, West Yorkshire BD11 2HW	Declined.
444	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	9/2/19	£355 sponsorship of diabetes course held on a weekend. NOI 13323	Mr Nicolas Price, Eli Lilly & Company Ltd., Priestley Road, Basingstoke, Hampshire, RG24 9NL	Accepted
445	Medical Education	WOD Centre Receptionist	9/2/19	£355 sponsorship of diabetes course on weekend.	Jenny Mortimer, Boehringer Ingelhelm UK, Ellesfield Ave., Bracknell, Berkshire, RG12 8YS	Accepted
446	Thomas Ellul	Urology Registrar	24/6/19 – 26/6/19	Application for sponsorship to attend Urology conference. Funding offered by Storz – medical technology company to be paid via Urology Endowment Fund	Storz Medical Technology	Accepted
447	Daisy Wilcox	Acting Ward Manager of PICU, Mental Health Unit, Royal Glamorgan	April 2019	Charitable gift from BAM Construction Company of Art Work for PICU.	BAM Construction Company	Accepted
448	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	01/8/2018	£150 sponsorship of Junior Doctors Induction. NOI CT/13151 PO NO – EVT 1004923	BMA 5th Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, CF10 4DQ	Accepted

APPENDIX 5

NO.	NAME OF RECIPIENT	POST HELD / DIRECTORATE	DATE OF OFFER	NATURE OF OFFER	OFFERED BY	ACCEPTED / DECLINED
449	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	14/08/2018	£150 sponsorship of Junior Doctors Induction. NOI CT/13152	Bayer 400 South Oak Way Green Park Reading, Berks, RG2 6AD	Accepted451
450	Medical Education Centre, Royal Glamorgan Hospital	WOD Centre Receptionist	01/08/2018	£150.00 sponsorship at Junior Doctors Induction. NOI CT/13153	Sally Williams MSD Hertford Road Hoddesdon Hertfordshire, EN11 9BU	Accepted
451	Angela Hughes	Mental Health/CMHT Older Persons Mental Health Team	26/06/2019	Bottle of wine and thank you card.	Patient	Accepted
452	Karyn Matthews	Older Persons Mental Health Team Taff Ely	04/07/2019	Flowers	Patient	Accepted

Appendix 1.

CWM TAF MORGANNWG HEALTH BOARD
DECLARATIONS OF INTEREST 2018/19

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
Executive Directors and Board Members			
	Allison Williams	Chief Executive Officer	• Trustee & Non-Executive Director – Skills for Health Ltd (Workforce Development Trust – New Name). Charitable Company – unpaid. • Husband employee of WAST.
	Christopher Turner	Independent Member	• Senior Professional Fellow (Honorary), Cardiff University. • Independent Governor – Cardiff Metropolitan University. • Interim Chair of EASC.
	Clare Llewellyn	Associate Member	• Work as Associate Trainer and external Quality Assurer for Agored Cymru. • Freelance Internal verifier for Valleys Kids.
	Dilys Jouvenat	Independent Member	• Chair of RCT Citizens Advice (may be involved in delivering projects via SLA with the Health Board).

Appendix 1.

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
	Gaynor Jones	Independent Member	• Chair RCN Welsh Board. • Member RCN Trade Union Committee.
	Gwenan Roberts	Interim Board Secretary Perm Role: Head of Corporate Services	• Partner works in Blood Bank Pathology, Royal Glamorgan.
	Ian Wells	Independent Board Member	• Research with NWIS & UWTSD.
	James Hehir	Independent Member	• Director, Llandarcy Park Ltd. • Solicitor of the Supreme Court. • HMCTS Clerk to the Dyfed Powys & North Wales Justices. • Member Law Society England & Wales. • Member Neath Port Talbot Law Society. • Member Swansea Law Society. • Member Neath Port Talbot Contact Centre. • Council Member Justices' Clerks Society. • Member Justices' Clerks Society. • Associate Member Magistrates' Association. • Honorary Vice President West Glamorgan Magistrates' Association.

Appendix 1.

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
			• Clerk to the Neath Port Talbot Justices. • Clerk to the Neath Port Talbot & Swansea Justices. • Patron Neath YMCA. • Member of Liberal Democrats.
	Jayne Sadgrove	Independent Member	• Member of Staff, Cardiff University. • Daughter-in-law is a member of staff in Royal Glamorgan Hospital.
	Keiron Montague	Independent Member	• Staff member of Cynon Taf Community Housing ending on 31 January 2019. • Trustee of Merthyr and the Valleys Mind. • Trustee of Full Circle Education CIC. • Independent Member of the Supporting People National Advisory Board. • Staff Member of Trivallis Starting 4 Feb 2019.
	Kelechi Nnoaham	Director of Public Health	• Spouse works for the Health Board.
	Marcus Longley	Chair	• Board Member, Professional Standards Authority for Health and Social Care.
	Maria Thomas	Vice Chair	• Justice of the Peace. • Executive Member MacMillan Cancer Support Merthyr Tydfil.

	NAME	DESIGNATION	INTEREST OF INDIVIDUAL, SPOUSE OR PARTNER
			• Trustee Safer Merthyr Tydfil. • Chair of Governors Gwaunfarren School. • Consultant Governor South Wales Consortium. • Executive Member St Johns Eye Hospital Jerusalem. • Member of St Johns. • Director of Winchfawr Investments. • VAMT Trustee until July 2018.
	Mel Jehu	Independent Member	• Independent Member Police Crime Panel (South Wales Police). • (Trustee) Cancer Aid Merthyr Tydfil. • Chair RCT Council Standards Committee. • Trustee on Board Safety Merthyr Tydfil.
	Nicola Milligan	Independent Member	• RCN Welsh Board.
	Robert Williams	Board Secretary/Corporate Director	• Wife works as a HCSW, Cwm Taf UHB.
	Anne Phillimore	Interim Director of Workforce & Organisational Development	• Nursing & Midwifery Council – Lay Member of Fitness to Practice Panel

Appendix 1.

AGENDA ITEM
2.11

AUDIT COMMITTEE

AUDIT COMMITTEE SELF ASSESSMENT PROCESS

Date of meeting	28 October 2019
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Officer
Presented by	Gwenan Roberts, Head of Corporate Services
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION

This report provides Members with an update on the outcome of discussions held by Audit Committee Members in relation to the Committees Annual Assessment of Performance.

2. BACKGROUND

The Audit Committee carries out an annual assessment of its performance to help identify opportunities for improving the efficiency and effectiveness of its work. Previously this exercise had taken place at a formal Audit Committee meeting and was largely based around the completion of a self-assessment questionnaire (in line with the approach undertaken by other committees). This approach has generally worked well although the Committee felt that some questions set out in the current questionnaire were not entirely appropriate to the circumstances facing the Health Board at the present time. More significantly, there was also a risk that strict adherence to this approach could foster a tick-box mentality and potentially curtail the scope for identifying improvement opportunities.

3. ASSESSMENT

As a one-off trial, the Committee agreed to carry out this year's assessment by;

- Using the content of the current questionnaire and a preferred National Audit Office Questionnaire as background reading to this year's assessment; the 'conclusion' questions at the end of each section in the NAO Questionnaire were considered to be particularly helpful in stimulating thought and potential discussion points;
- inviting suggestions for improvement from the WAO and Internal Audit;
- Inviting suggestions for improvement from Executive Staff who attend the Committee on a regular basis;
- Collating the responses for discussion by Committee Members;
- Producing this 'action to be taken' report for consideration and formal sign-off at the next meeting of the Audit Committee.

The responses received and the suggested areas for improvement have been outlined in **Appendix 1.**

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the report.

Audit Committee

Annual Assessment of Committee Performance

Introduction

The Audit Committee carries out an annual assessment of its performance to help identify opportunities for improving the efficiency and effectiveness of its work. Previously this exercise had taken place at a formal Audit Committee meeting and was largely based around the completion of a self-assessment questionnaire (in line with the approach undertaken by other committees). This approach has generally worked well although the Committee felt that some questions set out in the current questionnaire were not entirely appropriate to the circumstances facing the Health Board at the present time. More significantly, there was also a risk that strict adherence to this approach could foster a tick-box mentality and potentially curtail the scope for identifying improvement opportunities.

With the above in mind, and as a one-off trial, the Committee agreed to carry out this year's assessment by;

- Using the content of the current questionnaire and a preferred National Audit Office Questionnaire as background reading to this year's assessment; the 'conclusion' questions at the end of each section in the NAO Questionnaire were considered to be particularly helpful in stimulating thought and potential discussion points;
- inviting suggestions for improvement from the WAO and Internal Audit;
- Inviting suggestions for improvement from Executive Staff who attend the Committee on a regular basis;
- Collating the responses for discussion by Committee Members;
- Producing this 'action to be taken' report for consideration and formal sign-off at the next meeting of the Audit Committee.

Responses Received and Suggestions for Improvement

The Committee is very grateful for the constructive and thought-provoking responses it received from the WAO and Internal Audit. Disappointingly, the Committee only received one response from Executive Staff.

The areas identified for potential improvement are set out below.

Frequency of Audit Committee Meetings and Attendance

- Assess the need for additional meetings to ensure the Committee does justice to the full range of reports put before Members;
- Consider the introduction of more 'private' IM meetings – before, after or between formal Audit Committee meetings; and
- Consider expanding the range of invitations to attend the Audit Committee to include relevant executive staff below Executive Director level as well as appropriate clinical staff.

Agenda Content

- Give greater emphasis to compliance considerations and other key areas of work including the Board Assurance Framework, clinical audit, risk management and the development of SLAs/LTA (these areas are particularly important given the wide ranging structural and organisational changes that are taking place at the present time); and
- Continue to press for a high standard of reporting; reports should be succinct and to the point and should contain the appropriate level of information to support assurance and scrutiny requirements.

Independent Member Skills (also relevant to new members on other committees)

- Improve the induction training of new Committee Members generally; provide a 'one page' induction summary of the work of the Audit Committee;
- Audit Committee Chair to meet new members to help develop shared understanding of Committee's work and responsibilities;
- Consider development of Audit Committee Handbook and appropriate Practice Notes (where appropriate) to help clarify Audit Committee Member role and responsibilities;
- Audit Committee Members to participate fully in Health Board's IM Development Programme covering all aspects of their work including scrutiny; and
- Provide Audit Committee Members with access to papers for all committees not just those committees where they are a Member.

Communication with other Committees

- Develop better communication, engagement and exchange of information (including 'good practice') with other committees such as FP&W, Q&S and the new ICT Committee.

Governance of Hosted Bodies

- Carry out review of Audit Committee's governance arrangements relating to hosted bodies i.e. WHSSC and EASC, to ensure they are both appropriate and sufficient. Once the outcome of the review is finalised allocate additional Committee time as necessary.

Progress reports will be produced for the consideration of the Audit Committee on a half yearly basis.

Decision Required

The Audit Committee is asked to approve the proposed way forward.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.1** **28 October 2019**

Audit Committee Report
CHARITABLE FUNDS

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 Liz Williams Elisabeth.Williams@wales.nhs.uk on 01443 443803.

Purpose of the Audit Committee Report
To advise the Audit Committee of the activity and balances on charitable funds for the period 1 June 2019 to 31 August 2019 and provides 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 2019-2022 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. • **APPROVE** the proposal to retain the investment surplus as a buffer, given recent volatility in the market and the UK political environment. • **APPROVE** the proposed changes to the Scheme of Delegation of duties for the authorisation of the charitable fund expenditure. • **APPROVE** the proposal of investing additional cash in the Ethical Investment Funds managed by the UHB's current provider CCLA. • **NOTE** the update on registering the change in charitable funds objects with the Charity Commission. • **APPROVE** the proposal to purchase the Small Society Lotteries (Non-Commercial) licence to accommodate staff lottery within the Princess of Wales Hospital.						

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 June 2019 to 31 August 2019. The report also provides an update on the matters associated with the Bridgend Boundary Change and other matters of interest.

2. BACKGROUND / INTRODUCTION

The previous report to the Audit Committee highlighted balances and transactions up to 31 May 2019. This report updates the position as at 31 August 2019 and provides further analysis over their use by both fund type and location. An update is also provided on the investment performance, and proposal of distribution of the gain in capital value of the investments over the 20% threshold.

This report also provides an update on a number of matters associated with the Bridgend Boundary Change. In addition, a review of the Scheme of Delegation of Duties for the approval of charitable funds expenditure is detailed within this report.

BALANCES HELD BY THE CHARITABLE FUND

Balances held by the Charitable Fund as at 31 August 2019 are summarised in **Appendix A** analysed by fund type and location. Income received and expenditure incurred during the period 1 June to 31 August is also shown.

The balance at the end of August is £3.016m which is inclusive of £1.039m transferred from the Swansea Bay UHB on 31 May 2019 for the charitable funds transferred due to the Bridgend Boundary Change Project.

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 31 August 2019 is shown in **Appendix B.** Actions agreed with fundholders and other relevant observations are included within the comments section.

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, again with comments where appropriate.

INVESTMENT

The total units held remain at 783,307.83.

The market value at 31 August was £1.993m (an increase of £86k from the end of May), compared to £1.5m invested (i.e. a surplus of £493k – 32.8%).

The Investment Strategy for Cwm Taf Morgannwg NHS Chritable Funds states that: *Should the reserve exceed 20% of the overall investment, any excess will be distributed to individual fund balances, subject to Audit Committee approval.*

Due to the volatility of the markets during the previous financial year, Trustees decided not to distribute any surpluses to individual funds at its annual meeting in October 2018. Any surpluses therefore have been retained centrally as a buffer in the event of any future falls in investment values for the time-being.

The market value of the investment has now increased by 32.8% and in accordance with the Investment Strategy, the trustees are requested to consider the options noted in **Appendix D**.

Forecast income for 2019-20 is currently £62k – an income yield of 3.25%. Actual income received for 2018-19 was £63k

A graphical presentation of the investment performance by week, along with a FTSE100 comparator, is shown in **Appendix C**.

SCHEME OF DELEGATION OF DUTIES

A review of the Scheme of Delegation of Duties for the approval of charitable fund expenditure has been carried out in response to the recent organisational changes. **Appendix F** shows the current and proposed delegated limits along with the delegated limits for the other Welsh NHS Charitable Funds.

BRIDGEND BOUNDARY CHANGE

a) **Investment of additional cash**

As noted above, the bank balance has now increased by £1.039m due to the transfer of funds from the Swansea Bay UHB. The current rate of interest earned within the bank account is 0.3%. Therefore in order to achieve a higher rate of return on investment, it is advisable that the surplus cash, over and above that needed as working capital, is invested in the Ethical Investment Funds via our current investment management firm CCLA.

It is advisable that £500k of this cash is invested in the Ethical Investment Funds and the remaining balance is kept in the bank account as working capital. The working capital needs will be re-reviewed after the end of the current financial year and an assessment will be carried out of any further investments into the Ethical Investment Funds.

b) **Change of Charitable Fund Purposes**

As reported to the Committee previously, the purposes or objects of the Charity required amending to incorporate additional wordings as highlighted in bold below:

"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****"*

A written consent was received by the Charity Commission for the proposed changes to amend the objects of the charitable funds.

Subsequent to the July Audit Committee meeting, the Supplemental Deed approving the above changes was formally completed in August 2019. The document has now been submitted to the Charity Commission and we are currently awaiting formal acknowledgement of the receipt from the Commission.

c) **Staff Raffles/Lottery**

Within the Princess of Wales Hospital, the staff have been running staff raffles/lottery to raise funds for the benefits of staff and patients. In order to continue with this activity, the organisation is required to purchase a Small Society Lotteries (Non-Commercial) licence from the local authority (Rhondda Cynon Taff County Borough Council).

Currently, the Cwm Taf Morgannwg UHB does not operate staff lottery/raffles and thus does not hold this licence. However, it is advisable that a Small Society Lotteries licence should be purchased in order for the continuation of these fund raising activities at the Princess of Wales Hospital.

The cost of the licence for initial registration is £40 and thereafter a £20 annual fee is payable for the renewal of the licence.

In accordance with the terms and conditions of the licence, an income statement is required to be submitted within 3 months of the fund raising activity. The explanatory notes for the guidance of small Society Lotteries is attached at **Appendix E1** and a copy of the application form is attached at **Appendix E2**.

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 the Swansea Bay UHB 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.
- **APPROVE** the proposal to retain the investment surplus as a buffer, given recent volatility in the market and the UK political environment.
- **APPROVE** the proposed changes to the Scheme of Delegation of duties for the authorisation of the charitable fund expenditure.
- **APPROVE** the proposal of investing additional cash in the Ethical Investment Funds managed by the UHB's current provider CCLA.
- **NOTE** the update on registering the change in charitable funds objects with the Charity Commission.
- **APPROVE** the proposal to purchase the Small Society Lotteries (Non-Commercial) licence to accommodate staff lottery within the Princess of Wales Hospital.

Freedom of Information Status	Open

APPENDIX A

Summary of Funds and Transactions 01.04.19- 31.08.19

No of Funds 31.03.18	No of Funds 31.03.19	No of Funds 31.08.19		Previous Period(s) Balance 31.03.19 £	Income Apr - May £	Expend. Apr - May £	Revised Balance £	Income Jun - Aug £	Expend Jun - Aug £	Balance 31.08.19 £
A			**By TYPE**							
10	10	78	General Purposes	£435,706.25	£1,015,503.50	£(4,599.39)	£1,446,610.36	£100,411.73	£(13,285.07)	£1,533,737.02
65	58	60	Specific Purposes	£1,168,822.99	£53,880.13	£(4,705.74)	£1,217,997.38	£23,910.46	£(11,715.93)	£1,230,191.91
5	5	5	Post Graduate Education	£28,173.33	£0.00	£0.00	£28,173.33	£41.08	£(207.23)	£28,007.18
13	13	13	Research	£226,328.74	£4,879.08	£(2,027.84)	£229,179.98	£5,247.24	£(9,624.60)	£224,802.62
93	**86**	**156**	**Total**	**£1,859,031.31**	**£1,074,262.71**	**£(11,332.97)**	**£2,921,961.05**	**£129,610.51**	**£(34,832.83)**	**£3,016,738.73**
B			**By Location**							
33	31	30	RGH	£276,415.36	£1,050.00	£(1,941.35)	£275,524.01	£3,607.08	£(7,117.42)	£272,013.67
17	15	15	PCH	£364,109.46	£5,648.00	£(1,884.53)	£367,872.93	£6,907.84	£(8,683.00)	£366,097.77
0	0	71	POW	£1,038,769.83	£15,001.88	£(1,137.95)	£1,052,633.76	£95,746.32	£(8,728.44)	£1,139,651.64
9	11	11	RGH/PCH Combined	£500,474.93	£8,100.91	£(2,765.00)	£505,810.84	£2,314.38	£(2,211.40)	£505,913.82
7	6	6	YCR	£26,818.61	£699.00	£(545.43)	£26,972.18	£435.99	£(130.00)	£27,278.17
6	6	6	YCC	£311,065.98	£4,353.23	£(3,007.32)	£312,411.89	£12,792.91	£(7,098.02)	£318,106.78
1	1	1	Dewi Sant	£597.22	£0.00	£0.00	£597.22	£0.72	£0.00	£597.94
1	1	1	Y Bwthyn	£62,072.31	£265.00	£0.00	£62,337.31	£77.82	£0.00	£62,415.13
4	1	1	YGT	£4,830.22	£0.00	£0.00	£4,830.22	£1,748.25	£(657.32)	£5,921.15
5	5	5	Mental Health Unit	£13,191.93	£0.00	£(51.39)	£13,140.54	£753.51	£(207.23)	£13,686.82
1	1	1	CAMHS	£10,527.20	£0.00	£0.00	£10,527.20	£13.23	£0.00	£10,540.43
4	3	3	Community	£10,583.18	£0.00	£0.00	£10,583.18	£13.05	£0.00	£10,596.23
3	4	4	LHB Wide	£278,344.91	£374.86	£0.00	£278,719.77	£767.58	£0.00	£279,487.35
1	1	1	Other	£0.00	£0.00	£0.00	£0.00	£4,431.83	£0.00	£4,431.83
92	**86**	**156**		**£2,897,801.14**	**£35,492.88**	**£(11,332.97)**	**£2,921,961.05**	**£129,610.51**	**£(34,832.83)**	**£3,016,738.73**

A	Low Value and Slow Moving Funds	Definition - fund balances below £1,000 as at 31.08.19	APPENDIX B

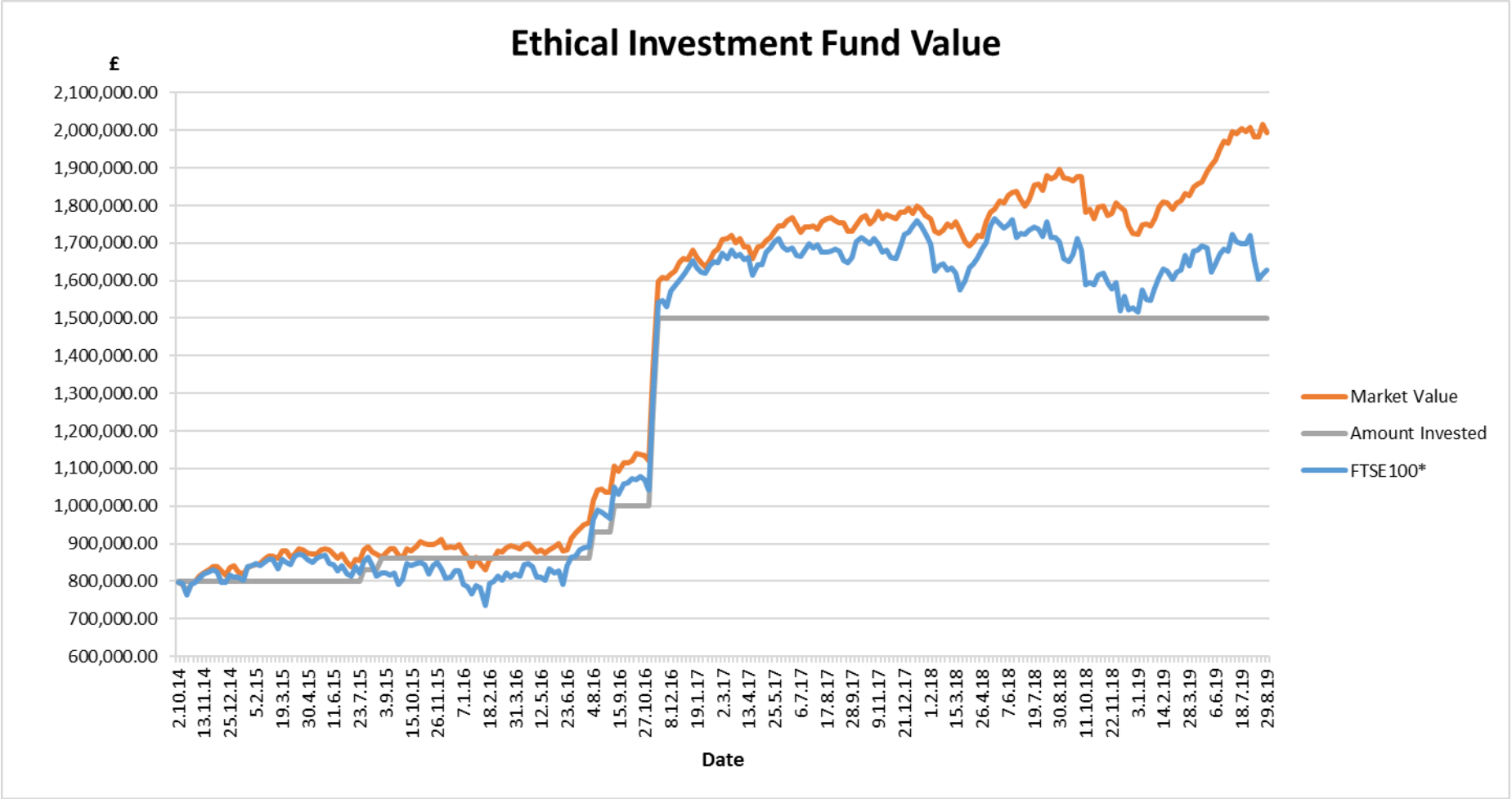
Fund No.	Fund Type	Location	Balance as at 31.8.19	Comments
9304	General Purposes	POW	£165.42	P.O.W Fund - meeting to be arranged to discuss.
9306	General Purposes	POW	£720.57	P.O.W Fund - meeting to be arranged to discuss.
9313	General Purposes	POW	£736.85	P.O.W Fund - meeting to be arranged to discuss.
9318	General Purposes	POW	£199.99	P.O.W Fund - meeting to be arranged to discuss.
9322	General Purposes	POW	£680.14	P.O.W Fund - meeting to be arranged to discuss.
9332	General Purposes	POW	£589.26	P.O.W Fund - meeting to be arranged to discuss.
9335	General Purposes	POW	£784.13	P.O.W Fund - meeting to be arranged to discuss.
9339	General Purposes	POW	£788.10	P.O.W Fund - meeting to be arranged to discuss.
9350	General Purposes	POW	£680.00	P.O.W Fund - meeting to be arranged to discuss.
9352	General Purposes	POW	£693.24	P.O.W Fund - meeting to be arranged to discuss.
9353	General Purposes	POW	£216.00	P.O.W Fund - meeting to be arranged to discuss.
9357	General Purposes	POW	£806.59	P.O.W Fund - meeting to be arranged to discuss.
9362	General Purposes	POW	£322.27	P.O.W Fund - meeting to be arranged to discuss.
9363	General Purposes	POW	£483.64	P.O.W Fund - meeting to be arranged to discuss.
9364	General Purposes	POW	£265.97	P.O.W Fund - meeting to be arranged to discuss.
9371	General Purposes	POW	£402.75	P.O.W Fund - meeting to be arranged to discuss.
9422	Post graduate Education	Mental Health Unit	£551.73	Expenditure has been received.
9423	Post graduate Education	Mental Health Unit	£470.96	Expenditure has been received.
9459	RESEARCH	RGH	£872.31	Fund Manager requested to keep fund open.
9465	RESEARCH	RGH	£612.23	Fund requested to remain open
9483	Specific Purposes	RGH	£880.57	Endoscopy - Fund to be used for training day. Reminder has been sent
9506	RESEARCH	RGH	£210.07	Requested to keep fund open. Income expected for information packs.
9516	Specific Purposes	RGH	£4.65	Fund is used regularly.
9519	Specific Purposes	RGH	£912.18	Requested to keep fund open.
9604	Specific Purposes	Dewi Sant	£597.94	Dewi Sant Day Unit replaced by @home service. Fund will be closed.

9680	Specific Purposes	YCR	£713.83	Requested to keep fund open. Fund is used
9824	Specific Purposes	RGH/PCH Combined	£947.45	Expecting expenditure for patients' quiet room / bad news room.
9826	RESEARCH	PCH	£372.41	Fund holder contacted for advice.
9850	Specific Purposes	LHB WIDE	£305.73	Primary Care Fund. Requested to keep fund open.
9874	Specific Purposes	YCC	£306.17	Fund holder requested to keep fund open.

B	Low Activity Funds	Definition - balance over £ 1k but no expenditure against fund in last 6 months *other than management charges.*	APPENDIX B

Fund No.	Fund Type	Location	Balance as at 31.8.19	Comments
9453	Specific Purposes	RGH	£1,306.35	Expenditure is expected.
9456	Specific Purposes	RGH	£1,416.72	RGH SCBU Fund -requested to keep this fund to be used & closed within 6 months
9463	Specific Purposes	PCH	£9,932.08	PCH SCBU Fund on hold waiting for unit to be completed.
9469	Specific Purposes	RGH/PCH Combined	£3,412.83	Fund holder to be contacted.
9470	Specific Purposes	RGH	£3,063.15	Possibility of merging fund. Meeting to be arranged.
9472	Specific Purposes	RGH	£3,950.13	Fund holder is on temporary absence
9479	Specific Purposes	RGH	£5,665.96	Fund will be closed - possibility of transferring to Giving To Pink Fund.
9482	Specific Purposes	RGH	£2,412.56	A&E Fund - will wait until changes to location have been implemented.
9485	Post graduate Education	RGH/PCH Combined	£7,673.85	New fund holder - will be contacted
9486	Specific Purposes	RGH	£3,096.32	Meeting was held and expenditure is expected. Reminder has been sent
9494	RESEARCH	RGH	£12,780.97	Meeting was held and expenditure is expected. Reminder has been sent
9499	RESEARCH	RGH/PCH Combined	£14,923.45	Meeting to be arranged to discuss.
9501	Specific Purposes	RGH	£2,360.85	Fund holder contacted
9505	RESEARCH	RGH	£4,392.83	Radiology - fund holder to be sent reminder to request information/spending plan.
9508	RESEARCH	RGH	£27,233.38	Fund Holder to be contacted.
9510	Specific Purposes	RGH	£2,102.63	Fund holder to be contacted.
9521	Specific Purposes	RGH	£21,238.14	Expenditure expected.
9526	Specific Purposes	RGH/PCH Combined	£10,370.41	Paediatric fund - expenditure on hold waiting for South Wales plan to be implemented
9600	General Purposes	Y Bwthyn	£61,115.13	Will be used to purchase new items for the new palliative care unit once built.
9650	General Purposes	Community	£2,438.05	Requested to keep fund open for future requests for aids for patient comforts.
9677	Specific Purposes	YCR	£8,224.10	Fund holder has been contacted.
9681	Specific Purposes	YCR	£1,335.18	Fund holder has been contacted.
9730	General Purposes	Community	£6,753.10	Requested to keep fund open for future requests for aids for patient comforts.

9731	Specific Purposes	Community	£1,405.08	Requested to keep fund open for future requests for aids for patient comforts.
9750	Specific Purposes	YCR	£1,875.41	Fund holder has been contacted.
9801	Specific Purposes	PCH	£33,327.64	Meeting to be arranged to discuss.
9802	Specific Purposes	PCH	£7,118.05	Meeting was held and expenditure is expected. Reminder has been sent
9803	Specific Purposes	PCH	£5,509.53	Fund Holder contacted
9809	RESEARCH	PCH	£11,149.95	Meeting to be arranged to discuss.
9825	Specific Purposes	PCH	£34,430.82	Fund hold contacted - meeting arranged.
9827	Specific Purposes	PCH	£7,477.02	Meeting was held and expenditure is expected. Reminder has been sent
9829	Specific Purposes	RGH	£7,109.27	Requested to keep fund open.
9885	General Purposes	LHB WIDE	£4,912.95	Chief Executive to be informed
9888	Specific Purposes	YCC	£7,867.77	Fund holder has been contacted.
9891	Specific Purposes	YCC	£1,604.71	Fund holder has been contacted.


Ethical Investment Fund Value
£
2,100,000.00
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
13.11.14
25.12.14
5.2.15
19.3.15
30.4.15
11.6.15
23.7.15
3.9.15
15.10.15
26.11.15
7.1.16
18.2.16
31.3.16
12.5.16
23.6.16
4.8.16
15.9.16
27.10.16
8.12.16
19.1.17
2.3.17
13.4.17
25.5.17
6.7.17
17.8.17
28.9.17
9.11.17
21.12.17
1.2.18
15.3.18
26.4.18
7.6.18
19.7.18
30.8.18
11.10.18
22.11.18
3.1.19
14.2.19
28.3.19
6.6.19
18.7.19
29.8.19
Date
Market Value
Amount Invested
FTSE100*

Appendix D

INVESTMENT

Cash balances not planned to be used in the foreseeable future are invested in Unit Funds managed by CCLA. £1.5m of the fund balance has been invested to date, resulting in an annual income of approximately £64k pa.

The market value of this investment as at 31st August 2019 was £1.992m – an unrealised surplus of £492k, representing 32.8% of the original investment

The Investment Strategy previously agreed by the Audit Committee states that a distribution of the capital to individual funds should be considered should the market value exceed 20% of cost (i.e. £1.8m). This threshold has been reached, although clearly there is scope for reductions before year-end. Should it be decided to distribute the funds, then £192k will be available for distribution based on the value of the holding at the end of August 2019.

Options available are:

i) Keep in the investment reserve as a buffer for any future downward movement in the value of the investment (over and above the 20% that is already being kept for this purpose). Further assessment of these options is proposed once the UK political environment is more settled.

ii) Distribute and apportion over all historical Cwm Taf UHB funds on the same broad basis as investment income/administrative costs, but taking into account that the surplus has been built up over a number of years.

iii) Distribute but keep as a central general purpose fund to be used for UHB wide initiatives. Given that these surpluses are derived from the investment of Cwm Taf UHB funds, it is suggested that they should be "protected" for use within the historical Cwm Taf UHB area.

Recommendation:

Option 1 is the preferred option to agree to retain the investment surplus as a buffer, given current volatility in the market and the UK political environment.

Further review of the above options is proposed once the UK political environment is more settled.

Scheme of Delegation - Charitable Funds Expenditure

APPENDIX F

	Under £ 1k	Up to £ 5k	Up to £ 10k	Up to £ 15k	Up to £ 20k	Up to £ 25k	Up to £30k	Up to £ 50k	Over £50k
Cwm Taf Morgannwg UHB - current	Designated fund signatories subject to confirmation from the Senior Finance Officer that sufficient funds are available	Designated fund signatories subject to confirmation from the Senior Finance Officer that sufficient funds are available	CEO or Deputy CEO	CEO or Deputy CEO	CEO or Deputy CEO	CEO or Deputy CEO	CEO or Deputy CEO	CEO or Deputy CEO	CEO or Deputy CEO

Appendix E1

EXPLANATORY NOTES FOR THE GUIDANCE OF SMALL SOCIETY LOTTERIES

GAMBLING ACT 2005

1. INTRODUCTION

Paragraph 32 of schedule 11 of the Gambling Act 2005 provides that a small society lottery may be promoted for any of the purposes for which the promoting society is conducted.

2. REGISTRATION OF SOCIETY

The following are extracts of paragraphs from Part 4 of Schedule 11 of the Act:

30. (1) A lottery is exempt if—
    (a) it is promoted wholly on behalf of a non-commercial society ("the promoting society"),
    (b) it is a small lottery (within the meaning of paragraph 31), and
    (c) the other conditions of a small society lottery specified in this Part are satisfied.

    (2) A lottery promoted wholly on behalf of a non-commercial society is referred to in this Part as a small society lottery.

31. (1) For the purposes of this Part a society lottery is a small lottery unless it is a large lottery by virtue of any of sub-paragraphs (2) to (5).

    (2) A society lottery is a large lottery if the arrangements for it are such that its proceeds may exceed £20,000.

    (3) A society lottery is a large lottery if it is promoted wholly or partly at a time in a calendar year at which the aggregate of the promoting society's proceeds from society lotteries promoted wholly or partly during that year exceeds £250,000.

    (4) A society lottery is a large lottery if the arrangements for it are such that (disregarding any other society lottery the sale of tickets for which is not concluded) it may during its promotion become a large lottery by virtue of sub-paragraph (3).

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(5) If a society promotes a lottery that is a large society lottery by virtue of sub-paragraph (2), (3) or (4) ("the first lottery"), any other society lottery promoted by that society is a large lottery if it is wholly or partly promoted—
(a) after the beginning of the promotion of the first lottery and in a calendar year during which the first lottery is wholly or partly promoted, or
(b) in any of the three calendar years successively following the last calendar year during which the first lottery was wholly or partly promoted.

Minimum distribution for fund-raising purpose

33. The arrangements for a small society lottery must ensure that at least 20% of the proceeds of the lottery are applied to a purpose for which the society is conducted.

Maximum prize

34. It must not be possible for the purchaser of a ticket in a small society lottery to win by virtue of that ticket (whether in money, money's worth, or partly the one and partly the other) more than £25,000.

Rollover

35. (1) The arrangements for a small society lottery may include a rollover only if each other lottery which may be affected by the rollover is a small society lottery promoted by or on behalf of the same society.

(2) This paragraph is subject to paragraph 34.

Tickets

36. (1) Where a person purchases a lottery ticket in a small society lottery he must receive a document which—
(a) identifies the promoting society,
(b) states the price of the ticket,
(c) states the name and an address of –
(i) a member of the society who is designated, by persons acting on behalf of the society, as having responsibility within the society for the promotion of the lottery, or
(ii) if there is one, the external lottery manager, and
(d) either—
(i) states the date of the draw (or each draw) in the lottery, or
(ii) enables the date of the draw (or each draw) in the lottery to be determined.

(2) For the purpose of sub-paragraph (1) a reference to a person receiving a document includes, in particular, a reference to a message being sent or displayed to him electronically in a manner which enables him to -
(a) retain the message electronically, or
(b) print it.

Price

37. (1) The price payable for each ticket in a small society lottery—
(a) must be the same, and
(b) must be paid to the promoter of the lottery before any person is given the ticket or any right in respect of membership of the class among whom prizes are to be allocated.

(2) Membership of the class among whom prizes in a small society lottery are allocated may not be dependent on making any payment (apart from payment of the price of a ticket).

Registration

38. The promoting society of a small society lottery must, throughout the period during which the lottery is promoted, be registered with a local authority in accordance with Part 5 of the Schedule.

Filing of records

39. (1) The promoting society of a small society lottery must send to the local authority with which the society is registered under Part 5 of this Schedule a statement of the matters specified in sub-paragraph (2).

(2) Those matters are—
- (a) the arrangements for the lottery (including the dates on which tickets were available for sale or supply, the dates of any draw and the arrangements for prizes (including any rollover),
- (b) the proceeds of the lottery,
- (c) the amounts deducted by the promoters of the lottery in respect of the provision of prizes (including the provision of prizes in accordance with any rollover),
- (d) the amounts deducted by the promoters of the lottery in respect of other costs incurred in organising the lottery,
- (e) any amount applied to a purpose for which the promoting society is conducted, and
- (f) whether any expenses in connection with the lottery were defrayed otherwise than by deduction from proceeds, and, if they were—
  - (i) the amount of the expenses, and
  - (iii) the sources from which they were defrayed.

(3) The statement must be sent to the local authority during the period of **three months** beginning with the day on which the draw (or the last draw) in the lottery takes place.

(4) The statement must be—
- (a) signed by two members of the society who are appointed for the purpose in writing by the society or, if it has one, its governing body, and
- (b) accompanied by a copy of the appointment under paragraph (a).

(5) A member signing a statement in accordance with sub-paragraph (4) must be an adult.

Application

42. (1) A society may apply to the relevant local authority for registration under this Part.

(2) An application under this paragraph—
- (a) must be in the prescribed form,
- (b) must specify the purposes for which the society is conducted,
- (c) must contain such other information, and be accompanied by such documents, as may be prescribed, and
- (d) must be accompanied by the prescribed fee.

43. In relation to the registration of a society, the relevant local authority is the local authority for the area in which the principal premises of the society are situated.

Refusal of registration

47. A local authority shall refuse an application for registration if in the period of five years ending with the date of the application -
    (a) an operating licence held by the applicant for registration has been revoked under section 119(1), or
    (b) an application for an operating licence made by the applicant for registration has been refused.

48. A local authority may refuse an application for registration if they think that—
    (a) the applicant is not a non-commercial society,
    (b) a person who will or may be connected with the promotion of the lottery has been convicted of a relevant offence, or
    (c) information provided in or with the application for registration is false or misleading.

49. A local authority may not refuse an application for registration unless they have given the applicant an opportunity to make representations.

Revocation

50. (1) A local authority may revoke a registration under this Part if they think that they would be obliged or permitted to refuse an application for the registration were it being made anew.

    (2) Where a local authority revoke a registration under this Part they shall specify that the revocation takes effect—
        (a) immediately, or
        (b) at the end of such period, beginning with the day of the revocation and not exceeding two months, as they may specify.

    (3) A local authority may not revoke a registration under this Part unless they have given the registered society an opportunity to make representations.

Appeal

51. (1) If a local authority refuse or revoke registration under this Part -
        (a) the authority shall notify the applicant society or the formerly registered society as soon as is reasonably practicable, and
        (b) the society may appeal to a magistrates' court.

    (2) An appeal under this paragraph must be instituted -
        (a) in a magistrates' court for a local justice area which is wholly or partly within the area of the local authority against whose decision the appeal is brought,
        (b) by notice of appeal given to the designated officer, and
        (c) in the period of 21 days beginning with the day on which the society is notified of the refusal or revocation of registration, and

    (3) On an appeal under this paragraph a magistrates' court may—
        (a) affirm the local authority's decision;
        (b) reverse the local authority's decision;
        (c) make any other order (which may include transitional provision).

Cancellation

52. A registered society may apply in writing to the registering authority for the registration to be cancelled.

53. As soon as is reasonably practicable after receipt of an application under paragraph 52 a local authority shall—
    (a) cancel the registration,
    (b) notify the formerly registered society of the cancellation, and
    (c) notify the Commission of the cancellation.

Annual fee

54. (1) A registered society shall pay an annual fee to the registering local authority.

    (2) An annual fee -
        (a) shall be paid within such period before each anniversary of the registration as may be prescribed, and
        (b) shall be of the prescribed amount.

    (3) If a registered society fails to comply with this paragraph the registering authority may cancel the society's registration.

    (4) If a local authority cancel a registration under sub-paragraph (3) the authority shall as soon as is reasonably practicable notify -
        (a) the formerly registered society, and
        (b) the Commission.

Regulation 5 of The small society Lotteries (Registration of Non - Commercial Societies) Regulations 2007 has prescribed the annual fee as £20 which must be paid within the period of two months which ends immediately before each anniversary of the registration.

Small Society Lotteries: breaches of condition

Section 262 of the Gambling Act states a non - commercial society commits an offence if -

(a) a lottery, purporting to be an exempt lottery under Part 4 of Schedule 11, is promoted on the society's behalf wholly or partly at a time when the society is not registered with a local authority in accordance with Part 5 of that Schedule,
(b) the society fails to comply with the requirements of paragraph 39 of that Schedule, or
(c) the society provides false or misleading information for the purposes of paragraph 39 of that Schedule.

Rhondda Cynon Taf County Borough Council
Licensing Section
Public Health & Protection
Ty Elai, Dinas Isaf East, Williamstown, Tonypandy CF40 1NY

Tel: 01443 425001 Fax: 01443 425301
Email: Licensing.Section@rctcbc.gov.uk

Mae'r ffurflen hon wedi'i rhagnodi gan reoliad 3(1) (a) o'r Rheoliadau Loteriau Cymdeithasol Bychan (Cofrestriad Cymdeithasau Anfasnachol) 2007

This form is prescribed by regulation 3(1) (a) of the Small Society Lotteries (Registration of Non- Commercial Societies) Regulations 2007

FFURFLEN GAIS AR GYFER COFRESTRU CYMDEITHAS ANFASNACHOL

APPLICATION FORM FOR REGISTRATION OF NON - COMMERCIAL SOCIETY

Os ydych yn cwblhau'r ffurflen hon yn ysgrifenedig, ysgrifennwch yn glir mewn priflythrennau gan ddefnyddio inc.

If you are completing by hand please write legibly in block capitals using ink.

At sylw: Cyngor Bwrdeistref Sirol Rhondda Cynon Taf Adran Drwyddedu Iechyd a Diogelwch y Cyhoedd Tŷ Elai, Dwyrain Dinas Isaf Trewiliam, Tonypandy CF40 1NY	To: Rhondda Cynon Taff County Borough Council Licensing Section Public Health & Protection Ty Elai, Dinas Isaf East Williamstown, Tonypandy CF40 1NY	Mae'r adran hon at ddefnydd swyddogol yn unig. / This section is for official use only.

ADRAN A - Manylion y gymdeithas sy'n gwneud cais am gofrestriad
SECTION A - Details of society applying for registration

1. Enw'r gymdeithas / Name of society. .....
.....

2. Cyfeiriad (gan gynnwys cod post) y swyddfa neu brif swyddfa'r gymdeithas / Address (including postcode) of office or head office of society
.....
.....
.....
.....
.....

3. Rhif ffôn y gymdeithas / Telephone number of society .....

4. Nodwch bwrpas(au) ar gyfer sefydlu a rhedeg y gymdeithas / Please state the purpose(s) for which the society is established and conducted
.....
.....
.....
.....
.....
.....

5. Os yw'r gymdeithas yn elusen gofrestredig, rhowch rif cofrestru unigryw yr elusen / If the society is a registered charity, please give the society's unique charity registration number
.....

6. Ydy'r gymdeithas wedi cael trwydded weithredol dan Ddeddf Gamblo 2005 yn ystod y pum mlynedd tan ddyddiad y cais hwn? / Has the society held an operating licence under the Gambling Act 2005 in the period of five years ending with the date of this application?

Ydy/Yes ☐ Nac ydy/No ☐

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Flare Ref.

7. Os ‘Ydy’ yw’r ateb i gwestiwn 6, ydy’r drwydded weithredol wedi ei diddymu yn ystod y pum mlynedd tan ddyddiad y cais hwn? / If the answer to question 6 is 'Yes', has the operating licence been revoked in the period of five years ending with the date of this application?

Ydy/Yes ☐ Nac ydy/No ☐

8. Os ‘Ydy’ yw’r ateb i gwestiwn 7, rhowch resymau dros y diddymiad ac amgaewch gopi o hysbysiad y diddymiad os oes un ar gael. / If the answer to question 7 is 'Yes', please state reasons for revocation and enclose a copy of the notice of revocation if one is available

.....

.....

9. Ydy’r gymdeithas wedi gwneud cais am drwydded weithredol yn ystod y pum mlynedd tan ddyddiad y cais hwn sydd wedi ei wrthod? / Has the society applied for and been refused an operating licence in the period of five years ending with the date of this application?

Ydy/Yes ☐ Nac ydy/No ☐

ADRAN B – Gwybodaeth gyffredinol ynglŷn â’r person sy’n gwneud cais ar ran y gymdeithas
SECTION B - General information about person applying on behalf of society

10. Enw / Name .....

11. Swydd / Capacity .....

12. Cyfeiriad (gan gynnwys cod post) / Address (including postcode)

.....

.....

.....

13. Rhif ffôn yn ystod y dydd / Daytime telephone number .....

ADRAN C – Manylion cyswllt ar gyfer gohebiaeth yn ymwneud â’r cais hwn
SECTION C - Contact details for correspondence associated with this application

14. Ticiwch un blwch sy’n briodol i nodi’r cyfeiriad ar gyfer gohebiaeth i’r cais hwn: /
Please tick one box as appropriate to indicate address for correspondence in relation to this application:

Cyfeiriad yn adran A / Address in section A	Cyfeiriad yn adran B / Address in section B	Cyfeiriad isod / Address below
☐	☐	☐

Cyfeiriad (gan gynnwys cod post) / Address (including postcode)

.....

.....

.....

.....

Rhif ffôn / Telephone number .....

Cyfeiriad e-bost (os yw’r ymgeisydd yn hapus i’r ohebiaeth sy’n ymwneud â’r cais hwn gael ei hanfon trwy e-bost) / Email address (if the applicant is happy for correspondence in relation to this application to be sent via e-mail) .....

ADRAN D – Datganiad
SECTION D – Declaration

15. Cwblhewch y datganiad a'r rhestr wirio ganlynol: /
Please complete the following declaration and checklist:

Rydw i *[enw llawn*] / I *[full name*] .....

a. yn gwneud y cais hwn ar ran y gymdeithas y cyfeirir ati yn Adran A ac mae gen i'r awdurdod i weithredu ar ran y gymdeithas honno. / make this application on behalf of the society referred to in Section A and have the authority to act on behalf of that society.

b. **Amgaeaf y taliad cofrestru sef £40. / Enclose payment of the registration fee of £40.**

c. Rwy'n cadarnhau, o'r hyn y gwn i, bod y wybodaeth sydd wedi'i chynnwys yn y cais hwn yn wir. Deallaf ei bod yn drosedd dan adran 342 o Ddeddf Gamblo 2005 i roi gwybodaeth sy'n anghywir neu'n gamarweiniol yn y cais hwn neu sy'n ymwneud â'r cais hwn. /
Confirm that, to the best of my knowledge, the information contained in this application is true. I understand that it is an offence under section 342 of the Gambling Act 2005 to give information which is false or misleading in, or in relation to this application.

Llofnod / Signature .....

Dyddiad / Date .....

Swydd / Capacity .....

Nodyn i gymdeithasau sy'n gwneud cais i gofrestru:

Bydd y cais hwn yn cael ei wrthod os, yn y pum mlynedd o fewn dyddiad y cais, fod y canlynol yn wir:

a) Bod trwydded weithredol y gymdeithas yn cael ei diddymu dan adran 119(1) Deddf Gamblo 2005, neu
b) Bod cais am drwydded weithredol gan y gymdeithas yn cael ei wrthod.

Gall y cais gael ei wrthod os yw'r awdurdod yn credu:

a) nad yw'r gymdeithas yn un anfasnachol,
b) bod y person sy'n cael ei gysylltu, neu a all gael ei gysylltu â hyrwyddo'r loteri, wedi'i ddyfarnu'n euog o drosedd berthnasol, neu fod y wybodaeth a ddarparwyd yn y cais neu gyda'r cais yn anghywir neu'n gamarweiniol.

Note to societies applying for registration:

The application will be refused if in the period of five years ending with the date of the application:

a) an operating licence held by the society has been revoked under section 119(1) of the Gambling Act 2005, or
b) an application for an operating licence made by the society has been refused.

The application may be refused if the local authority think that:

a) the society is not a non - commercial society,
b) the person who will or may be connected with the promotion of the lottery has been convicted of a relevant offence, or information provided in or with the application is false or misleading.

Hoffwn i dderbyn gohebiaeth (ticiwch) / I would prefer to receive correspondence in (please tick) **YN GYMRAEG/ WELSH** ☐ **YN SAESNEG/ ENGLISH** ☐

FURTHER INFORMATION REQUIRED

Name of Society: _____

Society Ref (existing holders only)**:** _____

Promoter Name: _____

Signed: _____

Address: _____

_____ **Postcode:** _____

Date of Birth: _____ **Preferred Telephone Number:** _____

Email: _____

N.B. THE PROMOTER NAMED ABOVE CANNOT BE ONE OF THE AUTHORISED SIGNATORIES.

We the undersigned are authorised by the above person to sign lottery returns on behalf of the Society.

1st Signatory

Print Name: _____

Signed: _____

Designation: _____

Date of Birth: _____

Address: _____

_____ Postcode: _____

2nd Signatory

Print Name: _____

Signed: _____

Designation: _____

Date of Birth: _____

Address: _____

_____ Postcode: _____

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cwm Taf Morgannwg University Health Board

INTERNAL AUDIT PROGRESS REPORT

Audit Committee - October 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

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2. Outcomes from completed audit reviews 1
3. Delivery of the 2019/20 Internal Audit plan 2
4. Performance monitoring 2

Appendix A:

Table 1: Status of assignments

Table 2: 2019/20 reviews already reported

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 Morgannwg 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

1.1. This progress report provides the Audit Committee (the 'committee') with the current position regarding the work undertaken by Internal Audit since papers for the committee were submitted on 18 October 2019.

1.2. The report includes details of the progress made to date against individual assignments.

2. Outcomes from completed audit reviews

2.1 Since the July meeting of the committee seven reports have been finalised, and five reports are in draft. The finalised reports 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.

Reports	Assurance rating
Retention of staff -follow up	Limited
Carbon reduction commitment	Substantial
Data quality – Patient pathway appointment management process	Limited
Consultant job planning	Limited
Primary care cluster plans	Reasonable
WHSSC - Directorate review of Cardiac	Reasonable
WHSSC – Information Governance	Reasonable

3. Delivery of 2019/20 Internal Audit plan

3.1 Our plan for the 2019/20 programme of work was approved at the Audit Committee on 1 April 2019. We have set out the progress against the plan in tables of Appendix A.

3.2 The tables include 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. Performance monitoring

4.1 In the table below we set out the current position of performance against the agreed measures for the 2019/20 programme of work.

Performance measure*	Reviews	Notes
Report turnaround: Time from fieldwork completion to draft reporting (10 working days) Target:80%	14/15 (93%)	Reviews > 10 days: • Data quality - patient pathway (16 days)
Report turnaround: Time taken for management response to draft report (15 working days) Target:80%	6/11 (55%)	Reviews > 15 days: • Radiology - compliance • Radiology – management arrangements • Data quality patient pathway • Retention of staff follow up • Consultant Job Planning
Report turnaround: Time from management response to issue of final report (10 working days) Target:80%	11/11 (100%)	-

**Information for core Internal Audit team only*

4.2 In addition, after each audit review is finalised we issue a performance questionnaire. The questionnaire covers areas such as the professional conduct of the auditor, the opportunity to discuss findings, and overall satisfaction.

4.3 We report the number of performance questionnaires issued and the response rate to date for the 2019/20 work programme:

- Number of questionnaires issued: 11
- Number of responses received: 6 (54%)

Note: The response rate is affected by the timing of the issue of the questionnaire and the completion of this progress report.

Table 1: Status of CTM assignments to be reported in the October Audit Committee or later, excluding Q4 reviews

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Retention of staff - follow up	5	Final	Limited	Q1	-
Carbon reduction commitment	-	Final	Substantial	-	-
Data quality – Patient pathway appointment management process	15	Final	Limited	-	Was brought forward from the 2018/19 Internal Audit plan
Consultant job planning	20	Final	Limited	Q1	-
Primary care cluster plans	15	Final	Reasonable	Q1	-
Planned preventative maintenance	20	Draft	Limited	Q2	Draft report issued 10.09.19
Raising concerns – follow up	5	Draft	Reasonable	Q1	Draft report issued 27.09.19
Directorate review – Pathology –	30	Draft	Reasonable x3	Q1	Draft report issued 30.09.19

Appendix A

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
management arrangements					
Directorate review – Pathology - compliance	15	Draft	Reasonable	Q1	Draft report issued 30.09.19
Digitisation project	15	Draft	Reasonable	Q2	Draft report issued 30.09.19
Information governance – Medical records management	15	WIP	-	Q2	Debriefing 18.10.19.
Directorate review – Head & Neck – management arrangements	30	WIP	-	Q2	-
Directorate review – Head & Neck - compliance	15	WIP	-	Q2	-
Health & Safety	20	WIP	-	Q2	-
Nurse Staffing Levels Act (Wales) 2016	20	WIP	-	Q2	-

Appendix A

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Medical equipment review – including follow up	20	WIP	-	Q2	-
Medical agency usage	20	Scoped	-	Q3	Planned start November – draft ToR has been issued. This review will capture Bridgend element originally proposed in separate medical staffing review
Nursing agency usage	20	Scoped	-	Q3	Planned start November – draft ToR has been issued
Rostering – medical staff	20	Scoped	-	Q3	Planned start November – draft ToR has been issued
Directorate review – Acute & A&E – management arrangements	30	Scoping	-	Q3	Met with business partners need to meet COO. Fieldwork planned for mid-November
Directorate review – Acute & A&E - compliance	15	Scoping	-	Q3	Met with business partners need to meet COO. Fieldwork planned for mid-November
Directorate review – PoW directorate focus	30	Scoping	-	Q3	Met with Service Group General manager of PoW. Fieldwork planned for mid-November.

Appendix A

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
Acute – management arrangements					
Directorate review – PoW directorate focus Acute - compliance	15	Scoping	-	Q3	Met with Service Group General manager of PoW. Fieldwork planned for mid-November.
Risk Management	20	Scoping	-	Q3	Awaiting outcome of WAO/HiW report to avoid duplication
Management of major capital	25	Scoping	-	Q1	Ongoing discussions regarding focus. We are risk assessing, will be either Neo-nates project on Sunnyside project
Efficiency savings and Board	25	Scoping	-	Q2	Meet SW & MT on 16.10.19. MT to provide information to confirm area of focus
Data quality	15	-	-	Q3	Scoping meeting with Julie Keegan arranged
Transitional review	70	-	-	-	IT aspect - Nothing has changed as yet. Moving the IT services from SB to CTM is complicated as the different health boards use different technologies.

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
					There is a business case being jointly developed, so in terms of the audit, there is nothing to look at until we have seen business case

Table 2: Hosted body reviews

Assignment	Days in plan	Status	Assurance	Planned Timing	Notes
WHSSC - Directorate review of Cardiac	15	Final	Reasonable	Q1	-
WHSSC – Information Governance	15	Final	Reasonable	Q3	-
WHSSC – Quality team implementation	10	Scoping	-	Q3	-
EASC NEPTS	10	Scoped	-	Q3	Have had scoping meeting
EASC – Amber review	15	Scoping	-	Q3	Have had initial scoping review

Table 3: Reviews to be undertaken in 2020/21

Assignment	Days in plan	Status	Planned Timing	Notes
Governance arrangements – QS&R committee review	15	To be done in 20/21	Q1	Review to be paused as WAO and HiW undertaking review.
Outpatients	17	To be done in 20/21	Q2	Overlap with Data quality – Patient pathway appointment management process due to timing of planning. Follow up now in 2020/21.
Culture	20	To be done in 20/21	Q2	CTM is developing new values and behaviours. In addition, WAO undertaking work in this area. So our work will now be undertaken in 2020/21
Transformation project	15	To be done in 20/21	Q3	Delay to 20/21 to reflect timing of WG funding.
De-escalation project	20	To be done in 20/21	Q4	Following discussion with Board Secretary and Chief Executive consider undertaking in Q1 following Health Board's project review.

Table 4: Reviews to be reported in 2019/20 Annual Report already taken to Audit Committee

Assignment	Days in plan	Status	Assurance	Planned timing	Notes
Sustainability reporting	10	Final	Reasonable	Q1	-
Annual Quality Statement	5	Final	Reasonable	Q1	-
Freedom of Information	13	Final	Substantial	Q1	-
Prince Charles redevelopment - follow up	-	Final	Substantial	Q1	-
Radiology directorate – management arrangements	-	Final	3 x Reasonable	-	-
Radiology directorate - compliance	-	Final	Reasonable	-	-

Retention of Nursing Staff - Follow up

Internal Audit Report
2019/20

August 2019

Cwm Taf Morgannwg University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Original Action Plan and follow up position
Appendix B Assurance opinion and action plan risk rating

Review reference:	CTU19.20/38
Report status:	Final
Fieldwork commencement:	24 May 2019
Fieldwork completion:	18 June 2019
Draft report issued:	28 June 2019
Management response received:	24 July 2019
Final report issued:	2 August 2019
Auditors:	Emma Samways Elizabeth Vincent
Executive sign off:	Anne Phillimore – Interim Director of Workforce and Organisational Development
Distribution:	Hywel Daniel – Deputy Director of Workforce and Organisational Development Donna Hill – Interim Assistant Director Workforce and Organisational Development
Committee:	Audit Committee



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

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1. Introduction

This follow-up review was completed in line with the 2019/20 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

The original Retention of Nursing Staff internal audit report was finalised in October 2018 and highlighted a total of six issues which resulted in an overall assurance rating of 'Limited Assurance'.

The relevant lead for the assignment is the interim Director of Workforce and Organisational Development.

2. Scope and objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the Retention of Staff review that was undertaken as part of our 2018/19 work programme.

The scope of this follow up review **does not** aim to provide assurance against the full review scope and objective of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The main areas that this review sought to provide assurance on are:

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales.
- Adequate evidence is available to support the level of progress that has been made.
- The actions implemented have effectively addressed the issues highlighted during the original audit.

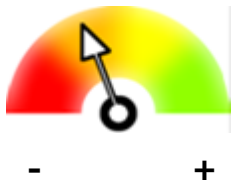
3. Associated risks

The potential risks considered in this review were as follows:

- Wards and departments unable to consistently operate in a safe manner due to insufficient staff.
- Additional costs incurred by the Health Board as a result of needing to employ agency staff or through additional recruitment campaigns.
- Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
- The failure to capitalise or reap the benefits of development investment in individuals.

4. Opinion

This review considers all recommendations made (high, medium or low priority). This follow-up review **does not** aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

Limited assurance		**Follow up -** No high level recommendations implemented but progress on a majority of the medium and low recommendations.

The Health Board has made some progress towards implementing the agreed management actions from the original review. However, we understand that the primary responsible officer for four of the six original management actions is no longer in post, which has slowed the progress against these actions.

The Nursing Retention Strategy and action plan has not changed since our original audit, and consequently the set of initiatives linked to the actions have not advanced. A further number of high level staff changes, and the merger of Bridgend services into the Health Board, have also hindered the progress against the agreed management actions.

The exit questionnaire and revised process has been completed and shared with appropriate staff. However, further work needs to be carried out to ensure that the planned prompts for managers are included on the termination form, awareness of the changes in the process is shared more widely and monitoring of the responses takes place in a timely manner.

The limited progress made against the original recommendations and agreed actions, specifically in relation to the strategy and action plan, means that the level of assurance that can be given to manage the risks associated with the Retention of Staff remains as **Limited Assurance**. As such we will undertake a further follow up review later in 2019/20.

5. Summary of audit findings

In summary, the Health Board's progress with its agreed management responses against the six recommendations that required implementation is as follows:

Priority rating	No. of recommenda-tions to be implemented	Fully implemented	Partially implemented	Not implem-ented
High	3	1	1	1
Medium	3	-	2	1
Low	-	-	-	-
Total	**6**	**1**	**3**	**2**

The action plan within Appendix A 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.

Evidence was provided to confirm that some action has been taken towards implementing three of the recommendations. Due to them being partially implemented this has reduced the priority rating for one, with the other two remaining at the original priority rating.

One of the six recommendations we have deemed as being implemented as, whilst no task and finish group was set up, monitoring took place elsewhere and the exit questionnaire process was revised. No progress has been made in implementing two recommendations – one high priority and one medium priority. Both of these relate to the revision of the Retention Strategy, Action plan and Implementation Plan.

Original Finding 1 – Nurse Retention Strategy and action plan (Control design)	Original Risk
As part of the 2018/21 IMTP acknowledgment is given to the significant pressures on the nursing workforce and the requirement to review the nursing recruitment and retention strategy with a focus on retention. At the time of our audit fieldwork the Nurse Retention Strategy and Retention Strategy Action Plan 2018/19 were in draft format and had been since March 2018. The two documents do not appear to be clearly linked as the strategic objectives detailed in the strategy document and the actions recorded in the action plan do not align. For example, the strategy is structured around five strategic aims whereas the action plan is structured around nine objectives. We would expect the actions to align with the strategic aims. Furthermore, during our fieldwork we were also provided with copies of the Health Board's draft Engagement Strategy and draft Leadership Strategy. It is not clear if consideration has been given to aligning the content of these, and any other key workforce and organisation development strategies, with the Nurse Retention Strategy.	Wards and departments unable to consistently operate in a safe manner due to insufficient staff.

Original Recommendation 1	Original Priority level
The objectives recorded in the 'Our Nurse Retention' Strategy and the actions in the Retention Strategy Action Plan should be aligned. All actions outlined in the Action Plan should contribute to the achievement of an objective. Both the 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan should be finalised. The Engagement Strategy, Leadership Strategy and Nurse Retention Strategy should be aligned, avoiding duplication between the three documents.	**High**
Original Management Response 1	**Original Responsible Officer/ Deadline**
1. The 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan will be finalised and in so doing the actions in the Retention Strategy will be aligned to objectives in the 'Our Nurse Retention' Strategy. 2. As the Engagement and Leadership Strategies are currently in draft, work will be undertaken to ensure that the Nurse Retention Strategy, which relates to the substance of this audit, aligns to the draft Engagement and Leadership Strategies in their current form. Areas of duplication and opportunities for synergies will be identified and any actions included in the Nurse Retention Strategy Action Plan.	Phillippa Doble, Head of Operational HR, January 2019 Phillippa Doble, Head of Operational HR, January 2019

Current Position	
The 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan have not been updated since our original audit and as such, there has been no alignment to the Engagement Strategy or Leadership Strategy. We understand that the individuals who were working on these documents either have moved to other posts or are no longer working for the Health Board. We note that our original report has been shared with the new Director of Nursing, Midwifery and Patient Care, and the draft strategy was on the agenda at the Nurse Workforce Group meeting held in April 2019 for comments and feedback, however, this version of the strategy is the same draft that was in place at the time of our original review. Limited progress has been made with the agreed management response and as such we consider this action to be **not implemented,** and remains a high priority.	
Updated Recommendation 1	**Updated Priority Level**
1. Building on the feedback received from the Nurse Workforce group the objectives recorded in the 'Our Nurse Retention' Strategy and the actions in the Retention Strategy Action Plan should be aligned. All actions outlined in the action plan should contribute to the achievement of an objective. 2. In addition, the strategy and action plan should be aligned to other appropriate leadership and engagement strategies. In addition, both the 'Our Nurse Retention' Strategy and the Retention Strategy Action Plan should be finalised as soon as practically possible.	**High**

Updated Management Response 1	Updated Responsible Officer / Deadline
Following discussion with the Interim CEO it has been agreed that a formal Workforce and OD strategy – of which Recruitment and Retention will be a key part, will be developed to support the emergent clinical services strategy (likely to be the last quarter of this year or in to next). Meanwhile the Health Board recognises the key importance of retaining our staff, particularly our nursing staff, and we will use the Nursing Workforce Group as the main vehicle to ensure that actions are agreed, implemented and monitored to agreed deadlines.	
At a meeting of the Nursing Workforce Group in July, the new Chair (Director of Nursing) determined that revised terms of reference were required to define the overarching purpose of the group, which should include the key activities/subgroups to support a broad range of initiatives, including nurse retention. The terms of reference have subsequently been redrafted and are due for sign off by the Nursing Workforce Group on 10th September 2019. The draft terms of reference confirm that the Group will review the activities of the identified sub-groups as their outputs will provide the initiatives and actions to ensure effective recruitment and retention of the nursing and midwifery workforce. The subgroups are defined as follows: 1. Career Development 2. Nurse Staffing Act 3. Temporary Staffing 4. Rostering Effectiveness 5. Recruitment 6. Health, wellbeing and engagement. Membership and deliverables will be reviewed and monitored by the Nursing Workforce Group.	Terms of reference agreed by NWG September 2019 Anne Phillimore IDW&OD Agreed action plans for groups October 2019 Donna Hill IADW&OD Progress against agreed actions available from March 2020

Original Finding 2 – Exit interview process (Control design)	Original Risk
We visited three wards where there has been staff turnover in the past year, to review the processes in place when staff leave the Health Board. Whilst there is no documented policy or procedure in place, we understand that departing staff are asked to complete an exit questionnaire which is followed up with an exit interview to understand the reasons for the employee's departure. However, from our discussions with the Ward Managers and Senior Nurses on these wards, and a discussion with HR, it was apparent that no exit questionnaires had been received by HR, and no exit interviews had taken place for these three wards. We note that no data in relation to exit interviews is provided to the Nursing Workforce Group as part of the staff utilisation report.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.
Original Recommendation 2	**Original Priority level**
The exit questionnaire and interview process should be reviewed, with a view to implementing a comprehensive process across the Health Board that will allow the effective gathering of data for analysis and presentation to relevant groups While this process is being formalised managers should be reminded of the importance of encouraging staff to complete exit questionnaires and to have an exit interview, with outcomes reported centrally.	**High**

Original Management Response 2	Original Responsible Officer/ Deadline
1. A review of the exit questionnaire and process has been undertaken. This has resulted in a new process which was presented to the Nursing Workforce Group in September. The group suggested changes to the questions, which will be amended and finalised in a meeting being held on 12 October. The process will then be piloted within nursing during the rest of October – December 2018. Alongside this an entry survey has also been developed to capture data on days 1, 30 and 90 which will also be piloted during the same period.	Phillippa Doble Head of Operational HR December 2018
2. All data captured from both exit and entry questionnaires will be presented to the Nursing Workforce Group monthly meeting. The importance of exit interviews is enforced at both the Snr Nurse Forum and the Nursing Workforce Groups meetings, which meet on a monthly basis. This is not a specific action of this audit, and occurs in any event.	December 2018
3. Once pilot is completed and evaluated, the process will be rolled out across all staff groups.	February 2019
Current Position	
1. The exit questionnaire and revised process has been made available to all staff since March 2019, which has been shared with members of the Nursing Workforce Group and the Senior Management Team. Due to staff departures and subsequent time delay, the questionnaire was not rolled out as a pilot as initially planned. A decision was	

made by the Acting Workforce Operational for the questionnaire to be used by all staff groups from its launch in order for data to start being captured. We consider this part of the management action to be implemented.

2. The new process introduced allows managers to provide the leaver with a link or copy of the exit questionnaire when the online termination form is completed. Going forward the Health Board plans to have a template email added to the termination form so that managers are prompted to send out the email, which will include the link to the exit questionnaire. A word version of the questionnaire will also be available on SharePoint. The new questionnaire gives the individual the option to request an exit interview with a specific member of staff, not just their manager.

   At the time of our fieldwork the number of exit questionnaire returns since the change in process was introduced was minimal. Fourteen returns have been made from the 159 staff who have voluntary resigned since March 2019.

   As it is the responsibility of the line manager/senior nurse to send a questionnaire, there is no way of knowing how many of the 159 staff were actually asked to complete the questionnaire. There is no requirement under the current process for HR to be copied into questionnaire requests that are sent out. As a result HR have no means of ensuring line managers/senior nurses are sending questionnaires to all leavers as they should be. We consider this part of the management action to not be implemented.

3. No analysis of the results, or trend monitoring has taken place as the Workforce team feels there has been insufficient data received to date. We were informed that when more data is available, monitoring will routinely take place at the Nursing Workforce Group, and then at CBMs when appropriate. However, the responses on those questionnaires received so far should be reviewed in order to allow any immediate concerns to be addressed. We consider this part of the management action to not be implemented.

We understand that advertising the changes to the exit questionnaire process was planned to go via the Health Board's homepage at the beginning of June 2019. However, due to the recent challenges faced by the Health Board management

decided to postpone this. In addition, changes to key staff, and the addition of the Bridgend are has meant that the Senior Nurse Forum has not met for some time.

Additionally, we have been informed by the Recruitment Project Manager that no progress has been made with regard to the 1, 30 and 90 day entry questionnaires. That was identified in the original management response.

As such, we consider the management actions in relation to the original finding to be **partially implemented.** While some progress has been made to date, there remains a significant amount of work to be completed before there is clear management information being obtained from the exit questionnaire process. As such, this recommendation remains a high priority.

Updated Recommendation 2	Updated Priority Level
1. The changes to the revised exit questionnaire process should be publicised throughout the Health Board as initially intended. 2. The template email should be included as part of the termination form in order to aid the issuing of questionnaires. 3. The Health Board should have a mechanism in place that allows it to ensure and monitor that staff who leave the Health Board are issued with an exit questionnaire by their line manager. 4. A review of those exit questionnaires received to date should be undertaken to ensure any concerns highlighted can be acted upon in a timely manner. Trend analysis can be undertaken as more completed questionnaires are received.	**High**

Updated Management Response 2	Updated Responsible Officer / Deadline
1. A revised communication plan will be developed to ensure the exit process is rolled out to all staff groups, including Princess of Wales.	August 2019 Donna Hill IDW&OD
2. The template is a link via the termination form which automatically prompts the individual to complete a questionnaire. This is also being reviewed by the All Wales Hire to Retire ESR group with a view to ESR driving the process.	September 2019 Donna Hill IDW&OD
3. Exit interview outputs are centralised and scrutinised by the HR Business Partners for any concerns to be taken forward. It is not practical for a resource to compare each leaver against the returned exit questionnaire however metrics are run on return rates by Directorate and are fed through to the HRBPs for inclusion in CBMs.	September 2019 Donna Hill IDW&OD
4. As above, the exit questionnaire content is analysed centrally and reported on in the Exec Board and FP&W Board metrics paper.	September 2019 Anne Phillimore DW&OD

Original Finding 3 – Exit meeting Task and Finish Group (Control Design)	Original Risk
We were advised by the Head of Workforce Productivity that a Task & Finish Group has been established to review the processes being followed when nursing staff leave the Health Board. The group includes Business Partners, Organisational Development colleagues and Compliance and Governance staff. However, there are no terms of reference for the group and there are no minutes or agendas available for those meetings that have taken place. The group was due to meet fortnightly and report into the Nursing Workforce Group which meets monthly, who in turn report into the Efficiency and Evaluation Board. However, the group has only met twice since it was created in January 2018. In addition, we saw no evidence of information being reported from the Task & Finish Group to the Nursing Workforce Group.	Continued reduction in the Health Board's nursing workforce as a consequence of retention issues not being monitored and relevant actions not being taken.
Original Recommendation 3	**Original Priority level**
A decision should be made regarding the need for a Task and Finish Group to review the exit process. Where there is deemed to be an ongoing need for the group, management should consider developing a terms of reference confirming the purpose, authority, attendees and the frequency of meetings for the Group. Agendas and minutes should be produced for each of the Task and Finish Group exit process meeting held and progress updates should be reported to the Nursing Workforce Group on a regular basis.	**High**

Original Management Response 3	**Original Responsible Officer/ Deadline**
A decision has been made to undertake this piece of work by using a graduate trainee, rather than a Task & Finish Group. The work has now been completed, and ongoing management will be undertaken via the Senior Nurse Forum and Nursing Workforce Group, as mentioned in the response to Finding 2 above.	Phillippa Doble Head of Operational HR Completed
Current Position	
The original management response confirmed that the Task & Finish Group was no longer required and that the ongoing management of the exit interview process would be through Senior Nurse Forum and Nursing Workforce Group. Our review of the Nursing Workforce Group the minutes between September 2018 and March 2019 confirmed that this monitoring has occurred and an exit interview process is now in place. Therefore, we consider this management response to be **implemented**.	

Original Finding 4 – Timely use of survey data (Operating effectiveness)	Original Risk
During Summer 2017 a Health and Wellbeing Survey was undertaken by the Health Board. All staff were contacted by email or hard copies provided for those staff without email access. Over 1400 responses were received with 529 nursing staff responding. An initial review of responses was carried out by the Occupational Health and Wellbeing Manager in January 2018. However, the analysis and write up of the survey results in relation to nursing staff did not take place until April 2018. The completed surveys included a lot of changes requested by the nursing staff. Trends and themes were identified including: how staff rate their current physical and emotional health; what initiatives staff are interested in; which aspects of healthy behaviours impact on staff health and wellbeing; which communication channels do staff have access to in different areas; what themes and ideas for improvement have been expressed by the workforce; and are there any activities or initiatives that could be put in place. The length of delay in analysing the data captured in the survey appears to be 'time lost' where quick wins could have more quickly taken place to respond to the outcome of the survey. Aside from this survey, and the ongoing all Wales NHS staff survey which will provide directorate level responses, there have been no other attempts to gather staff views and opinions via 'pulse surveys' at a departmental level.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.

Original Recommendation 4	Original Priority level
Where surveys are undertaken, results should be analysed and reported in a timely manner to ascertain if there are any trends or themes that need to be acted upon. The perceived lack of action may discourage staff from completing surveys in the future. 'Pulse surveys' should be carried out on a regular basis with nursing staff to assess the opinions of staff and ascertain if they have any concerns in work.	**Medium**
Original Management Response 4	**Original Responsible Officer/ Deadline**
In relation to the staff Health and Wellbeing survey which was conducted during the Summer of 2017, the results were collated in January 2018 and as the nurses were the largest responders (529 nurses responded representing 37% of the overall response rate) a more detailed analysis of their feedback was collated in February. The findings were presented at the Nurse Recruitment and Retention meeting on 8 March 2018. This was followed up with a detailed discussion with Lynda Williams, Director of Nursing on 24 April where it was agreed a workshop would be set up with the Director, the Assistant Director of Nursing and the Heads of Nursing. The workshop was held on the 11 July where analysis of the findings was presented and the group were able to conduct a qualitative analysis identifying key themes. From this work it was agreed that a Head of Nursing, Jane O'Kane, would join the organisations staff health and wellbeing group 'Feeling Fine, Working Well',	Karen Vaughan Occupational Health & Wellbeing Manager

and for the first time provide a voice for nursing staff on health and wellbeing issues. The idea is to establish a sub group dedicated to focusing on nurses and health care support workers as it is recognised this is a unique staffing group with specific working practices. Jane has already made links with Kerri Eilertsen-Feeney, Head of Midwifery, Gynaecology and Sexual Health, in relation to the Royal College of Midwifes (RCM) 'Caring 4 You' Charter to see if the principles of the charter can be adopted for the general nursing teams. The organisations sign up to the charter demonstrates its commitment to all midwifes and maternity support workers to improve health, safety and wellbeing at work. Kerri said: "Caring for staff is high on our agenda and we welcome this opportunity." It was felt the themes identified through the workshop such as communication, recognition and morale would be best addressed through a leadership programme which will be developed with the Organisational Development team. The nurse analysis of the survey will continue to be cascaded through the nursing networks via the senior nurse manager meetings with discussions on how the results can be utilised further to support staff health and wellbeing. During July and August 2018 a pedometer challenge was initiated and promoted to all staff groups via the staff intranet site and the staff champion network. This initiative was in support of the national physiotherapy campaign 'Love Activity, Hate Exercise'. The organisation supports and promotes various national and local health and wellbeing campaigns throughout the year. The All Wales staff survey has recently closed. High-level feedback will be	February 2019 November 2018

received on 12 November 2018. Regular pulse surveys will be conducted as part of the Engagement strategy.	January 2019
Current position	
We enquired as to what further staff surveys had been undertaken since the completion of our original audit, in order to confirm that survey results had been analysed and acted upon in a timely manner. We are aware that the results from the All Wales Staff survey, that was carried out in Autumn 2018, were shared with the directorate managers in early 2019, confirming timely review. We also note that work is ongoing following the analysis of the Health and Wellbeing Survey results in 2018. However, no other surveys, or pulse surveys have taken place since our original review. In addition, we were not provided with an update on the leadership development programme that was going to be developed around the themes that arose from the Health and Wellbeing workshop. Where there has been a survey, the results have been analysed in a timely manner, which was our overarching concern in our initial finding. However, as no 'pulse surveys' or similar have been conducted, the ongoing gathering of views and opinions at a department level has not taken place. As such, we consider this action to be **partially implemented.**	
Updated Recommendation 4	**Updated Priority Level**
1. 'Pulse surveys' or similar should be carried out on a regular basis with nursing staff to assess the opinions of staff and ascertain if they have any concerns in work. 2. Work to progress the leadership development programme in line with the	**Medium**

themes that arose from the Health and Wellbeing workshop should take place.	
Updated Management Response 4	**Updated Responsible Officer / Deadline**
1. It is important for any pulse surveys undertaken to be evidence based and to be able to provide comparative data. Work is being undertaken for Wales Workforce & OD Directors to review the staff survey with a view to surveying a much smaller number of questions. A report was received and endorsed by WODDs at their July 2019 meeting: "*The approach has two main strands which both focus on two way feedback, sharing successes and learning, jointly deciding on any actions that need to be taken, and making space to ensure that these are taken. In essence, it's a check-in to discuss wellbeing:* *1)Improve the quality of 1:1 conversations between line managers and their team members by raising the expectation of having a regular conversation with our manager. The conversation should also include how the relationship is progressing between with our manager. In essence it's a regular check-in, wellbeing, role clarity and growth conversation.* *2)Using survey results at a team/group level to have a conversation about improving wellbeing and experience in our area of work. The actions we decide upon should be a key part of what we commit to do in our local plans. Initially, whilst the surveys will be every 12 months, the results are just the prompt for our local conversations*". The recommended approach is currently with WG for consideration and includes a recommendation for a survey in September 2019.	Hywel Daniels DDW&OD

CTM will be able to take a view on options to use questions from a shorter staff survey for periodic pulse surveys. If a clear approach is not forthcoming via Welsh Government, then the Nursing Workforce Group will be consulted on a set of pulse survey questions and the targets business areas to be surveyed.	January 2020
2. The organisation is currently reviewing its Leadership and Management offering following the transition from CTUHB to CTMUHB. The findings from the Health and Wellbeing Survey will be taken into consideration to inform any subsequent programmes. Following the appointment of Assistant Director – OD, the associated Leadership and Management offering will need to be scoped out and presented to the Nursing Workforce Group.	Anne Phillimore IDW&OD and Hywel Daniels DDW&OD March 2020

Original Finding 5 – PDR documentation (Operating effectiveness)	Original Risk
PDRs should be completed for all staff on an annual basis. Part of their purpose is to allow staff to record their development requirements for the forthcoming year and to reflect on the previous year, allowing both staff and their line managers to take action as necessary, which may ultimately prevent a member of staff from leaving. We selected a sample of 29 staff across three wards to ensure that a PDR had been undertaken on an annual basis. We requested to see copies of the PDR (as opposed to confirming completion via ESR), in order to evidence that development requirements and concerns had been captured. Our findings are as follows: <u>Ward A</u> • There was no evidence of tracking and monitoring of PDRs on an annual basis for any that we reviewed. • 4/10 PDRs had been undertaken over 12 months ago. • 9/10 PDRs referred to specific issues on the ward such as staff morale. <u>Ward B</u> • 8/9 PDRs - There was no previous PDRs on the employee's personal file. • There was no evidence of tracking and monitoring of PDRs on an annual basis for any of the PDRs that we reviewed.	Continued reduction in the Health Board's nursing workforce including a loss of key talent, as a consequence of retention issues not being monitored and relevant actions not being taken.

• 1/9 PDR had been undertaken over 12 months ago. • 5/9 PDRs referred to specific issues on the ward such as staff morale. We did not identify any issues from our testing of sample of ten staff at the third ward. It is acknowledged detailed monitoring of PDR compliance on a directorate and ward basis is now closely monitored during the directorate Clinical Business Meetings.	
Original Recommendation 5	**Original Priority level**
PDRs should be undertaken on an annual basis with staff so that ongoing development can be captured to help retain staff including setting key objectives for the following year. PDRs should also be carried out to identify if there are any fundamental issues with the staff.	**Medium**
Original Management Response 5	**Original Responsible Officer/ Deadline**
PDRs are undertaken on an annual basis and recorded via ESR. In July 2018 PDR compliance was 73.95% against a target of 85% for the organisation with nursing and midwifery at 72.24%. Work continues through the CBMs to drive up compliance and PDR rates are reported monthly at every operational business meeting and quarterly for	Janet Gilbertson Interim Assistant Director Organisational Development

corporate areas. Compliance is also reported in the monthly Finance, Performance and Workforce Committee Report as part of the workforce metrics dashboard. A new draft PDR form has been designed as part of the Engagement Strategy but further work is required for finalisation at the beginning of 2019.	 January 2019
Current position	
A new PDR form has been designed which is being piloted in a number of departments/areas within the Health Board to ensure understanding and to get informed feedback from the end users before moving across completely to the new PDR form. The trials are taking place between May and July 2019. The new PDR documentation is currently available to staff via SharePoint. Once the final version meets the needs of all stakeholders, the new documentation will be incorporated into the PDR training. PDR compliance is monitored monthly at Clinical Business Meeting's and the Finance, Performance and Workforce (FP&W) committee. Testing of PDR completions and compliance rates also forms part of our Directorate audit reviews. However, we note from the May 2019 FP&W Committee papers that compliance rates have remained fairly static at 73.31% compared to the July 2018 rate of 73.95%. The Health Board is still not achieving the Welsh Government target of 85%. As such, we consider this action to be **partially implemented**.	

Updated Recommendation 5	Updated Priority Level
Staff should be reminded that PDRs should be undertaken on an annual basis so that ongoing development can be captured to help retain staff including setting key objectives for the following year. Following completion of the pilot scheme, the new PDR form should be rolled out across the Health Board using a planned approach.	**Medium**
Updated Management Response 5	**Updated Responsible Officer / Deadline**
1. Communication via the intranet will be issued to managers reminding them of the importance of undertaking PDRs for staff. 2. Following completion of the pilot scheme the new PDR form will be reviewed and consideration given to any amendments required following feedback. 3. A phased approach for the roll out will be submitted to the Nursing Workforce Group for approval.	Hywel Daniels DDW&OD September 2019 December 2019 January 2020

Original Finding 6 – Initiatives in place to retain nursing staff (Operating effectiveness)	Original Risk
Stemming from the Retention Strategy Action Plan we would have expected to have seen initiatives being developed as a means to implement the various actions identified. We have been informed by the Head of Workforce Productivity that some initiatives are in place. For example, Workforce are in the process of producing a 'Nursing Offer' for September 2018 that will confirm all grades within nursing, and the offer to 'new recruits' if they join, or already work within, the Health Board. Whilst these are mostly recruitment initiatives, there are also links to retention. In addition, the Health Board are hoping to introduce rotational roles whereby nurses can rotate between wards on a six monthly basis so they can experience work on different wards. However, currently there is no clear link between these initiatives and the action plan.	The failure to capitalise or reap the benefits of development investment in individuals.
Original Recommendation 6	**Original Priority level**
When developing the Retention Strategy Action Plan a clear set of initiatives should be included, linked to each of the actions, that will assist in the retention of nurses. Initiatives should have measurable targets attached to them that can be assessed.	**Medium**

Original Management Response 6	Original Responsible Officer/ Deadline
As per Finding 1, the action plan will be reviewed, with appropriate milestones and target timescales included. This will drive the development and implementation of new initiatives, such as the rotational posts, in a measureable manner. The action plan will be reported via the Nursing Workforce Group before the end of the year and that Group can drive communication across the nursing workforce within the Health Board.	Phillippa Doble Head of Operational HR January 2019 December 2019
Current position	
As per Finding 1, whilst the draft Retention Strategy was presented to the Nursing Workforce Group in April 2019, this was the same draft version that was available at the time of our original audit review. Therefore, no progress has been made on updating the Strategy or action plan or developing a set of initiatives. As such, we consider this action to be **not implemented**.	
Updated Recommendation 6	**Updated Priority Level**
When developing the Retention Strategy Action Plan a clear set of initiatives should be included, linked to each of the actions, that will assist in the retention of nurses. Initiatives should have measurable targets attached to them that can be assessed.	**Medium**

Updated Management Response 6	Updated Responsible Officer / Deadline
See updated management response 1 – The Nursing Workforce Group will received monthly/bi-monthly updates from the relevant subgroups, measuring their performance.	As updated management response 1

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.

Follow up - All recommendations implemented and operating as expected.

 **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.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **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.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

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

Follow up - No action taken to implement recommendations.

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 Pathway Appointment Management Process

Internal Audit Report

Cwm Taf Morgannwg University Health Board

October 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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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 and 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 Morgannwg 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 procedures around the arrangements for the patient pathway appointment booking process was planned to be undertaken in line with the 2018/19 Internal Audit Plan for Cwm Taf University Health Board (the 'Health Board'). Due to timing constraints, the review did not commence until April 2019 and as such will form part of the annual audit opinion for Cwm Taf Morgannwg for 2019/20.

The Health Board looks to ensure that patients receive the best and most appropriate treatment options available to them, within the shortest period of time. To facilitate this, the Health Board needs to manage waiting lists effectively and efficiently.

The current system for managing waiting lists measures the total waiting time from a General Practitioner (GP) or General Dental Practitioner (GDP) referral to the initiation of treatment, known as 'Referral to Treatment Time' (RTT). The implementation of RTT necessitated a change in waiting list management processes with staff needing to be more knowledgeable about the whole patient pathway than they had previously. In recent months the Health Board have undertaken a process mapping exercise confirming the booking process pathway to ensure consistent practices are followed. The directorates and key staff within them are responsible for managing their 'watch list' of patients to ensure patients move through their pathway without unnecessary delay.

The Health Board is required to record and report its performance against the following RTT targets as part of the performance measures within the NHS Wales Outcomes Framework:

- the percentage of patients waiting less than 26 weeks for treatment;
- the number of patients waiting more than 36 weeks treatment for treatment; and
- delivery of the 31 day (Non-Urgent Suspected Cancer) and 62 days (Urgent Suspected Cancer) cancer access standards.

The proper management of patient pathways through the booking process should facilitate the achievement of these objectives. As such, every stage of the patient's RTT pathway should be accurately recorded onto the Welsh Patient Administration System (WPAS) as the information entered on the system affects what happens to the patient.

The relevant leads for the review are the Director of Planning and Performance, Chief Operating Officer and Director of Primary, Community and Mental Health.

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 the appointment booking process within the patient pathway. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives were managed appropriately.

The areas that the review sought to provide assurance on are:

- The Health Board has appropriate and up to date procedures in place for the recording of patient data at each stage of their pathway to support the reporting of RTT performance data. Procedures align to Welsh Government guidance.
- Training in relation to the procedures has been provided where necessary.
- Directorates are complying with the Booking Process Pathway and are accurately, promptly and appropriately recording patient data on relevant systems to facilitate the achievement of RTT targets and reporting.
- Key staff within directorates are managing their 'watch lists' of patients to ensure action is taken in a timely manner.

The focus of the review was on the process arrangements for the patient pathway. As such, we did not undertake substantive testing of the underlying patient data. We undertook meetings with the Medical Secretaries in the areas of Orthopaedics and Rheumatology.

3. Associated Risks

The risks considered in the review were as follows:

- Inaccurate reporting of the RTT performance as a result of the Booking Process Pathway not being adhered to.
- RTT targets not achieved if issues are not identified at an early stage, reported and addressed.

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 within the Patient Pathway Appointment Management Process is **limited assurance**.

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

There were a number of significant issues identified within the review which could affect the reporting of numbers of patients to Welsh Government and there could be risks that patients are not being seen on a timely basis.

There are a number of policies and procedures in place for managing waiting lists within the Health Board including the Waiting List Management - RTT Standard Operating Procedure (SOP) which is up to date and aligns to the Welsh Government Revised Rules for Managing Referral to Treatment Waiting Times. In addition, the Health Board has undertaken a mapping exercise of the patient pathways to ensure that all areas were covered and this agrees to the Health Board's SOP.

The Welsh PAS team have produced a Secretary Information document outlining the process the Medical Secretaries should follow for managing the patient pathways and training is carried out in line with these documents. However, it was evident that there was no consistency of when the Secretary training was carried out as in many instances it is delivered as and when requested by the Secretaries or the Directorate Managers. Furthermore, temporary Secretaries are used when there are vacancies which was acknowledged could be a risk as they could be recording the

patient's pathway incorrectly and the permanent Medical Secretaries are having to review the temporary staff members work to ensure it is accurate.

At the time of our review it was highlighted that the WPAS team undertake overtime work to validate patient outcomes on WPAS that had potentially been incorrectly recorded. Furthermore, the WPAS team have to undertake checks to ensure patients are on the correct pathway, as in many cases pathways have been closed for patients when they are on a day case or an inpatient list and therefore should remain open, which is a risk as the patient might not receive the required treatment.

The Medical Secretaries are required to ensure that the patients who have further investigations such as scans and x-rays are monitored via a 'watch list' so that future appointments with Consultants can be arranged once test results are available. It was confirmed that the 'watch lists' were not user friendly and in many cases Medical Secretaries were using their own processes for chasing up patients that require further investigations.

5. Assurance Summary

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

Assurance Summary					
1	Health Board has appropriate and up to date procedures				✓
2	Training in relation to the procedures has been provided			✓	
3	Directorates are complying with the Booking Process Pathway		✓		
4	Key staff within directorates are managing their 'watch lists'			✓	

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

Design of Systems/Controls

The findings from the review did not identify any issues that are classified as a weakness in the system control/design for Patient Pathway Appointment Management Process.

Operation of System/Controls

The findings from the review highlighted five issues that are classified as weaknesses in the operation of the designed system/control for Patient Pathway Appointment Management Process.

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 appropriate and up to date procedures in place for the recording of patient data at each stage of their pathway to support the reporting of RTT performance data. Procedures align to Welsh Government guidance.

We note the following areas of good practice:

- The Health Board has a Waiting List Management - RTT Standard Operating Procedure that is up to date. Included in this document is the Welsh Government's revised rules for managing referral to treatment waiting times.
- The Health Board has undertaken a process mapping exercise of the patient pathway to ensure that all stages are covered. This aligns with the RTT Standard Operating Procedures.
- There is an information document detailing the process that Medical Secretaries need to follow when documenting patient information through the patient pathway process.

We did not identify any findings under this objective.

Objective 2: Training in relation to the procedures has been provided where necessary.

We note the following areas of good practice:

- Patient pathway training is provided to the medical secretaries by the Welsh PAS team. In addition, there are documented procedures in place for the secretaries that are used as part of the training.
- A test has been developed by the Welsh PAS team for the secretaries to check their understanding of RTT process. The test aligns with the secretary information document to ensure that the secretaries have understood the procedure.

We identified the following findings:

- Training was undertaken by the WPAS team for the Medical Secretaries, however, it was identified that training is undertaken as and when required following requests from individuals and directorates. This can often lead to last minute request for those staff due to commence employment, as opposed to dates being booked in advance.

  A test has been developed for Medical Secretaries to complete to check their understanding of the RTT process, however not all secretaries were consistently taking the test.

- Temporary Medical Secretaries are used when cover is needed for maternity or long-term sickness. The temporary secretaries do not receive the secretary training and their work requires review by the permanent Medical Secretaries, which is added workload for the permanent staff.

Objective 3: Directorates are complying with the Booking Process Pathway and are accurately, promptly and appropriately recording patient data on relevant systems to facilitate the achievement of RTT targets and reporting.

We identified the following findings:

- It is the responsibility of the Outpatients Reception to record the outcome following the patient's appointment. In addition, when the Medical Secretary produces the letter following the patient's appointment they should be checking that the outcome is recorded correctly. However, it was identified that the outcomes were not being recorded correctly on the Welsh PAS system and therefore the Welsh PAS team had to work overtime to validate the outcome of the patients. Due to the outcome being recorded incorrectly there is a risk that the patient is not having their appointment dealt with in a timely manner.

  Patients are provided with paper outcome forms confirming their next stage in the treatment but we were advised that the forms sometimes go astray and the patient's next stage on the pathway is not being updated on the system. The use of electronic forms was trialled in a number of directorates, with mixed success.

- We were advised that the Welsh PAS team email the directorates reports of patients that are recorded as being on a closed pathway, but where the pathway should have remained open due to the patient being on a day case or inpatient list. There is a risk that the pathway could be closed and the patient needs hospital admission and have not received their treatment which is a clinical risk for the patient and the RTT are being breached.

Objective 4: Key staff within directorates are managing their 'watch lists' of patients to ensure action is taken in a timely manner.

We identified the following finding:

- We met with Medical Secretaries within the Orthopaedics and Rheumatology directorates and note that a number of different processes are used to monitor patients awaiting diagnostic results. In addition, there is conflicting guidance available to staff on the process.

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**	**3**	**0**	**5**

Finding 1- Patient outcomes (Operating effectiveness)	Risk
Patients are referred to a Consultant for an appointment by either a GP or a GDP. Following their appointment, the patient is given an outcome form to hand to the receptionist outlining the next stage in the treatment pathway. The outcome can be 'no follow up required', or the need for a further appointment. It is the responsibility of the outpatient receptionist to input the outcome of the patient's appointment on WPAS. In addition, a Medical Secretary takes dictated notes from the Consultant and writes a letter summarising the outcome of the patient's appointment that is then sent to the patient. The Health Board's process requires the Medical Secretary to check that the outcome recorded on WPAS agrees to the outcome on the patient's letter that has been drafted. There are instances when the patient may fail to take their outcome form to the receptionist, the reception area may be closed, or forms go astray. Furthermore, the Medical Secretary may not check WPAS to ensure an outcome has been recorded. In addition, the Consultant might not dictate a letter and therefore the patient's outcome may be missed. The Welsh Government guidelines state that health boards '*ensure 100% compliance with outcome coding for any patient interaction, either face to face or virtual, to reduce the need for validation of un-coded activity*'. WPAS team run reports on a regular basis from WPAS, listing the number of patients where outcomes have not been recorded. These are sent to the Directorate Managers, Assistant Director for Performance and Information and	RTT targets not achieved if issues are not identified at an early stage, reported and addressed. Patients not appropriately moving to the next stage in their pathway in a timely manner or receiving treatment as required, if outcomes are incorrectly recorded.

Deputy Chief Operating Officer to highlight the issues in their area. We reviewed a sample of reports and note that outcomes were not being recorded for a number of patients. In January 2019, the outcome had not been recorded for 2,520 patients. In February, following additional validation work undertaken by the WPAS team through overtime, the numbers had reduced to 658 patients where the outcome had not been recorded. However, in May 2019 these numbers had increased to 1,686 patients as the WPAS team were no longer working additional hours on validation. Data is not available to allow the calculation of the proportion of patients that these figures represent, as such the scale of the problem of outcomes not recorded is unknown. There is a risk that if the patient's outcome is not being recorded on WPAS then the patient's future appointment is not being dealt with in a timely manner. Over the past two years a number of reports relating to the Follow Ups Not Booked (FUNB) matter have been presented to the Board and its committees. To help overcome this ongoing issue, in two directorates' (Medicine and Rheumatology) electronic outcome forms have been trialled. This involved Consultants inputting appointment outcomes directly into WPAS as opposed to completing a paper outcome form. In one area within Medicine (ENT) this approach appears to be working. However, in Rheumatology it appears to be less successful with some Consultants preferring to continue using the paper form, therefore the directorate has reverted back to paper forms.	

Recommendation	Priority level
1. Directorate Managers need to: • Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. • Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. • Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. Where necessary additional training should be requested to ensure that all staff are aware of their responsibilities in completing the above steps correctly. 2. Management should engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board should consider trialling the electronic outcome forms within all Directorates. 3. Consideration should be given as to how data can be captured to allow the calculation and monitoring of the proportion of patients whose outcome is not recorded on WPAS.	**High**

Management Response	Responsible Officer/ Deadline
We fully agree with all the recommendations and will incorporate this into our action plan. We intend to secure additional resource to assist in the monitoring and implementation of this action plan. A forum will be set up to oversee this work stream and detailed action plan.	Assistant Director of Scheduled Care in association with Assistant Director of Performance and Information and other Assistant Directors responsible for other speciality areas – by November 2019
A process of 'cashing up' at the end of every clinic is required to ensure clinic and administration staff have processed the patients using the outcome form and WPAS. This process needs to include the initiation of diagnostic tests and request forms being processed to cut down on 'dead time' waits for diagnostics. This process needs to be mandated and managed by the clinic manager. Temporary administration and nursing staff need to undertake mandatory training in cashing up clinics.	Assistant Directors – by March 2020 - on behalf of Chief Operating Officer & Director of Primary, Community and Mental Health for their respective specialities
The Assistant Director of Scheduled Care together with the Assistant Director of Performance and Information will engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board will consider trialling the electronic outcome forms within all Directorates.	Assistant Director of Scheduled Care and Assistant Director of Performance and Information – March 2020
An appointment with no outcome registered report needs to be circulated in order that administration managers can act on patients who have no outcome, validating the patient's position on the pathway.	

All staff need to understand the implications of failure to comply. Weekly reports need to be circulated to services including consultants with non-compliance addressed by relevant professional leads.	Assistant Director of Performance and Information – by December 2019 Weekly reports - Assistant Director Performance and Information – by December 2019 Oversight of Directorate communications and compliance – Assistant Directors – March 2020 - on behalf of Chief Operating Officer & Director of Primary, Community and Mental Health for their respective specialities

Finding 2 - Closed pathways (Operating effectiveness)	Risk
Following a patient's initial appointment, they follow either an 'open' or a 'closed' pathway. An open pathway is for a patient requiring further treatment. A closed pathway is for a patient that requires monitoring but does not require further treatment. We were advised by the WPAS team that each month they email all secretaries and other key staff within directorates a report identifying those patients that have been incorrectly input on WPAS on a closed pathway. For example, if the patient is on a day-case or inpatient list, and so should be on an open pathway. The April 2019 report sent by the WPAS team shows 200 patients who were incorrectly following a 'closed' pathway. In such cases, there is a potential risk that the pathway has been closed when in fact the patient may need further hospital appointments and potentially treatment.	RTT targets not achieved if issues are not identified at an early stage, reported and addressed. Incorrect reporting of RTT figures. Clinical risk for the patient if further appointments or treatment is not arranged.
Recommendation	**Priority level**
1. Directorate Managers and their teams should review the report of patients recorded as being on a closed pathway to ensure that they are on the correct pathway. Day-case and inpatients should be moved back to an open pathway so that they receive the required treatment on a timely basis. 2. Analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one directorate, department or person. Where necessary, further investigation should be	**High**

undertaken to why these errors are routinely occurring and further training provided. 3. Consideration should be given to escalating the incorrectly closed pathway reports to ensure Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue.	
Management Response	**Responsible Officer/ Deadline**
We are fully in agreement with the recommendations and will incorporate this into the action plan response (see above).	
Recommend clinic outcome letters are an opportunity to validate patient outcomes, a SOP will detail the actions to be taken to achieve this.	Assistant Director of Performance and Information and Assistant Director of Scheduled Care - December 2019.
Where staff are unable to achieve the required standards, a performance monitoring process will be instigated.	Oversight of Directorate compliance – Assistant Directors – March 2020 - on behalf of Chief Operating Officer & Director of Primary, Community and Mental Health for their respective specialities.
Agree there is a need for a regular monitoring report to be tabled at Directorate meetings for improvement purposes.	Regular monitoring report - Assistant Director Performance and Information – January 2019

Finding 3 - Welsh PAS training (Operating effectiveness)	Risk
The WPAS team provide training to Medical Secretaries that covers the process they need to follow to ensure that they are recording information correctly, and patients are on the correct pathway. Initial training was given to Medical Secretaries when WPAS was introduced in the past few years. Subsequently training has been provided to Medical Secretaries as and when requested. In addition to the provision of training, the WPAS team has developed a test for the Medical Secretaries to complete to check their understanding of the RTT process. The test is in line with the Secretary Information guidance and has been designed to ensure that the Secretaries have an understanding of the procedure. However, not all Medical Secretaries have sat the test. From our sample of three Orthopaedic Medical Secretaries, none had undertaken the test, however the two Rheumatology Medical Secretaries sampled had sat it. All five Secretaries had undertaken training with the WPAS team.	Inaccurate reporting of RTT performance as a result of the Booking Process Pathway not being adhered to
Recommendation	**Priority level**
Directorate Managers need to ensure that Medical Secretary training is consistently applied including completion of the Referral to Treatment test. Refresher training should be provided on a regular basis in line with PDR requirements and targeted to those employees who are identified as having a	**Medium**

higher numbers of input errors than expected. Where problems remain, consideration should be given to applying the appropriate Workforce and OD policy to manage the situation.	
Management Response	**Responsible Officer/ Deadline**
A performance monitoring tool will be developed to identify areas of focused intervention with direct performance monitoring for the Directorate teams.	Development of performance monitoring tool – Assistant Director of Performance and Information in association with operational Assistant Directors for their speciality areas – March 2020 Oversight of Directorate compliance – Assistant Directors – March 2020 - on behalf of Chief Operating Officer & Director of Primary, Community and Mental Health for their respective specialities.

Finding 4 - Temporary medical secretaries (Operating effectiveness)	Risk
From our discussions with a sample of Orthopaedic and Rheumatology Medical Secretaries, it was established that temporary medical secretaries are used to cover, amongst other things, maternity leave and long-term sickness. However, there may be multiple temporary staff who provide this cover, as opposed to one person covering the whole period. There is no clear training approach for temporary medical secretaries, and there is no requirement for them to have undertaken WPAS training prior to starting in the role. As such, there is a possibility of input errors. To address this their work is checked by the permanent Medical Secretaries to ensure that they are completing the letters correctly and that the patient has been input onto the correct pathway, which is an added workload for the permanent Secretaries.	Inaccurate reporting of RTT performance as a result of the Booking Process Pathway not being adhered to
Recommendation	**Priority level**
Service General Managers together with Directorate Managers should consider reviewing the process for using temporary Secretaries within the Health Board to ensure that all receive WPAS training ahead of commencing in a role.	**Medium**

Management Response	Responsible Officer/ Deadline
Temporary secretaries should not be used to manage Waiting List (WL) data input unless fully trained and long term temps. We will carry out a risk assessment to determine the feasibility of this followed by agreed implementation when feasible. These personnel should be used for letter backlogs and typing. Administration managers must ensure staff are fully trained.	Chief Operating Officer & Director of Primary, Community and Mental Health to raise and discuss with their Assistant Directors, in association with Directorate Managers – by March 2020 for their respective specialities.

Finding 5 - Watch lists (Operating effectiveness)	Risk
Medical Secretaries are required to monitor patients who are awaiting diagnostic investigation results. There appears to be conflicting guidance available as to how this monitoring should take place. The Waiting List Management – RTT Standard Operating Procedure refers to Medical Secretaries using QL reports to monitor patients. Through our discussions with the Medical Secretaries in Orthopaedics and Rheumatology reference was made to different guidance and the use of 'watch lists'. However, we confirmed that SharePoint contains a document called WPAS RTT Secretary Information – Watch List and QL. We note from our discussions with the Medical Secretaries that the 'watch lists' are not considered to be user friendly and so other systems are used as an alternative, such as spreadsheets, the QL reports or keeping the letters sent by the Consultants. We were further advised that the 'watch lists' are only visible to the Medical Secretary that have added the patient onto the individual 'watch lists'. As such, there is a risk that if the 'watch list' is not viewed regularly by the person who created the list, the patient's needs may not be followed up in good time. There appears to be inconsistent guidance issued to the Medical Secretaries and inconsistent processes in use.	RTT targets not achieved if issues are not identified at an early stage, reported and addressed.

Recommendation	Priority level
The process for monitoring patients who are awaiting diagnostic investigation results should be reviewed to ensure all Medical Secretaries are utilising a standard approach that is user friendly and does not restrict access, thus allowing visibility to other staff members.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A review of this process and guidance will be carried out, potentially with external support to assist and add pace to the review. Consistent guidance and emphasis on use will then be provided. Management teams will ensure that locally held spreadsheets are not replacing the mandatory addition to the formally report QL. Request internal audit re-assessment of this in next year's audit plan.	Assistant Director of Performance and Information – by April 2020. Assistant Director of Performance and Information – May 2020 if not before. Oversight of Directorate compliance – Assistant Directors – April 2020 - on behalf of Chief Operating Officer & Director of Primary, Community and Mental Health for their respective specialities. Internal Audit to consider as part of next year's plan – March 2020.

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

**No assurance** - The Board can take **no assurance** that arrangements 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.

Consultant Job Planning

Internal Audit Report

2019/20

Cwm Taf Morgannwg University Health Board

October 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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Executive sign off:	Anne Phillimore, Interim Director of Workforce and Organisational Development
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Committee:	Audit Committee

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

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

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1. Introduction and Background

Our review of Consultant Job Planning was completed in line with the 2019/20 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

A job plan can be described in simple terms as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and outcomes of the consultant, and the support and resources provided by the employer for the coming year.

Job planning became a central part of consultants' working lives with the agreement of the 2003 Amendment to the National Consultant Contract in Wales. This made explicit the link between job planning and a successful relationship between the consultant and their employer.

The job planning process provides an opportunity to align the objectives of the NHS, the organisation and clinical teams with individually agreed outcomes in order to allow consultants, clinical academics, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care.

Job plans record the work that a consultant will undertake for the Health Board, split by Direct Clinical Care (DCC), and Supporting Professional Activities (SPA). The plan documents the use of time and resources required to meet the individuals, departments and organisations objectives.

The testing undertaken in this review relates to consultants and SAS doctors at the Royal Glamorgan Hospital (RGH), Prince Charles Hospital (PCH) and Princess of Wales (PoW) Hospital.

The relevant lead for the review is the Interim Director of Workforce and Organisational Development.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the Consultant Job Planning process. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives were being managed appropriately.

The areas that the review sought to provide assurance on were:

- There is relevant and up to date guidance and procedures in place that are available to applicable staff, and align to All Wales guidance.
- Job planning and the annual review process complies with relevant guidance, with all parties engaged, plans reviewed and agreed in a timely manner ahead of the job plan period.
- Where job plans deviate from guidance, explanations are available to justify the deviation. For example, where more or less than ten sessions a week are carried out, or where the number of Supporting Professional Activity (SPA) sessions exceeds the guide number.

- Job plans include personal outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.
- The completion rates of job plans are monitored and reported with action taken as necessary for those areas failing to complete plans.
- Agreed job plans are input to ESR in a timely manner.
- Where consultants routinely work additional hours above their agreed job plan, this is authorised in advance and if necessary challenged as to why the hours are not incorporated into the job plan.

3. Associated Risks

The risks considered in the review were as follows:

- Sessions worked may not be sufficient to allow for adequate provision of service.
- Consultant job plans may not reflect actual conditions or be developed by mutual consent.
- Under or over payments may occur if job plan data is not accurately input in ESR in a timely manner.

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 established controls within the consultant job planning system is Limited Assurance.

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

The Health Board has produced its own tailored job planning guidance that was up to date and built on the guidance published by the Welsh Government in 2014. This guidance is due for review in November 2019, which will allow changes in relation to the Bridgend boundary change to be incorporated.

The Health Board has implemented the Allocate e-job planning system. The software should help ensure consistency by using a standard job plan template, and provide easy access to job plans for consultants and Speciality and Associate Specialist (SAS) doctors, and their line managers. It also enables real time monitoring by directorate management, and facilitates the production of accurate job planning statistics.

Since the April 2019 boundary change the Health Board has taken on an additional 187 consultants and SAS doctors based at PoW hospital in Bridgend. At the time of our audit 102 out of 597 consultants and SAS doctors (17%) employed across the Health Board had an up to date and fully signed off job plan in place. Additionally, 115 consultants and SAS doctors (19%) had no job plan in place. The remainder had job plans in place, although these were not current.

A key feature of the job planning process is the agreement of outcomes. Although all job plans that we reviewed included Health Board outcomes, these were generic and the same for all job plans. They appeared to lack detail and were activities rather than measurable outcomes which had no link to the Health Board's IMTP. Few of the job plans that we reviewed included

directorate or service outcomes, and although some included personal outcomes these lacked substance and were activities rather than measurable outcomes.

We also identified discrepancies between the number of sessions recorded in job plans and the number of sessions being paid, and the control over the payment of Additional Duty Hours and additional Commitment Award increments.

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	Guidance and Procedures				✓
2	Compliance with Guidance		✓		
3	Number and split of weekly sessions		✓		
4	Personal Outcomes		✓		
5	Reporting Job Plan Completion Rates			✓	
6	Input to ESR			✓	
7	Additional Worked Hours		✓		

** 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 weaknesses in the system control/design for consultant job planning.

Operation of System/Controls

The findings from the review have highlighted seven issues that are classified as weaknesses in the operation of the designed system/control for consultant job planning.

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 relevant and up to date guidance and procedures in place that are available to applicable staff and align to All Wales guidance.

We note the following area of good practice:

- Job planning guidance for consultants and SAS doctors was issued by the Cwm Taf Workforce and Organisational Development department in November 2017 and is available to all staff via SharePoint. This aligns to the job planning guidance for consultant medical and dental staff that was issued jointly by the NHS, BMA and NHS Wales Employers in April 2014.

We did not identify any findings under this objective.

Objective 2: Job planning and the annual review process complies with relevant guidance, with all parties engaged, plans reviewed and agreed in a timely manner ahead of the job plan period.

We note the following areas of good practice:

- Job plans are created using a template in the Allocate e-job planning system, which is accessible to all consultants and SAS doctors.
- There is a documented job plan 'sign-off' process that generates e-mail reminders to consultants and SAS doctors to sign off their job plans in the system.
- The sign-off process allows job plans to be 'proxy signed-off' in the system after 10 weeks if the consultant or SAS doctor does not reject the job plan or request alterations.

We identified the following findings:

- 31/50 job plans tested were not fully signed off by the individual, Clinical Director and Directorate Manager and 27/50 job plans tested were out of date and overdue for review.

  Overall only 17% of consultants and SAS doctors (102) had a current, signed-off job plan, with 19% having no job plan at all.
- In addition to the Allocate job planning system, job plan details are recorded in a separate database due to the reporting functionality in the Allocate system. However, the job plan 'status' was incorrectly recorded on the database for 8/50 consultants that we tested and the review date recorded on the job plan differed to that recorded on the database for 4/50 consultant job plans tested.

Objective 3: Where job plans deviate from guidance, explanations are available to justify the deviation. For example, where more or less than ten sessions a week are carried out, or where the number of Supporting Professional Activity (SPA) sessions exceeds the guide number.

We note the following area of good practice:

- The Allocate system has a section where explanatory notes can be provided to explain any deviances from the DCC / SPA split detailed in the Welsh Government Consultants Contract.

We identified the following findings:

- All of the PoW job plans that we reviewed predate the recent boundary change and are geared to deliver objectives and outcomes for the former Abertawe Bro Morgannwg University (ABMU) Health Board, which may not necessarily align with CTM objectives, and outcomes. Furthermore, many job plans detail sessions to be undertaken at sites that are now in the Swansea Bay area.
- Insufficient detail was recorded for SPA sessions for 11/50 job plans that we tested.

  The Health Board outcomes appeared generic and very similar for all of the job plans that we reviewed, with very little detail or substance.

  None of the job plans that we reviewed included service outcomes.

  The recording of rest breaks was inconsistently factored into timetables within the job plans, with some plans including breaks and others not.

Objective 4: Plans include personal outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.

We note the following areas of good practice:

- The Health Board's job planning guidance requires job plans to include personal outcomes linked to Health Board performance targets, SPA time and the individual's Personal Development Plans. The guidance also requires progress against outcome measures contained in job plans to be checked during the annual review process and on a six monthly basis and to provide feedback as appropriate.
- The Allocate system facilitates the recording of personal outcomes in job plans.

We identified the following findings:

- Only 30/70 job plans that we tested contained any personal outcomes. Where recorded, personal outcomes appeared to be brief and were generally activities rather than measurable outcomes.
- There was no evidence that there was any process in place to assess progress against personal outcomes.

Objective 5: The completion rates of job plans are monitored and reported with action taken as necessary for those areas failing to complete plans.

We note the following area of good practice:

- Job plan completion rates were being reported at individual Directorate Clinical Business Meetings.

Objective 6: Agreed job plans are input to ESR in a timely manner.

We did not identify any areas of good practice for this objective.

We identified the following findings:

- Our reconciliation of the number of sessions recorded on job plans to the number of sessions being paid for a sample of consultants and SAS doctors identified a number of issues and potential under or overpayments.
- The input of job planning data to the ESR system had lapsed and the system was not up to date. It was also unclear on the reasoning for inputting job plan data into ESR and the Job Planning Guidance document does not refer to the ESR system.

Objective 7: Where consultants routinely work additional hours above their agreed job plan, this is authorised in advance and if necessary challenged as to why the hours are not incorporated into the job plan.

We note the following area of good practice:

- There is an established process for claiming additional duty hours that requires the completion of a standard claim form.

We identified the following findings:

- There were several different versions of the standard claim form in use.
- For some of the job plans that we reviewed there appeared to be instances where the hours claimed potentially conflicted with the existing job planned hours according to the timetable contained within the job plan. Therefore, potentially resulting in consultants and SAS doctors being paid twice for working the same hours or working several shifts continuously.
- None of the claims forms that we tested had been signed by the Directorate Locum Booking Organiser or Authorising Consultant as evidence that the additional hours were approved in advance of being worked.
- There was a variation in pay rates claimed which were sometimes in hours, and sometimes sessions.

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	**5**	**2**	**1**	**8**

Finding 1 - Job plan completion and sign-off (Operating effectiveness)	Risk
The Health Board has a documented consultant job planning 'sign-off' process. Following a job planning meeting between the individual, the Clinical Director and Directorate Manager, the consultant or SAS doctor should agree their job plan within the Allocate system. If they are not happy with the content, they should notify their line manager of any suggested amendments or reject the plan, following which there will be further discussions. If consultants do none of these actions an e-mail reminder is sent after five weeks and a further reminder after nine weeks. If no objections to the plan have been received, but it is still not signed off by the consultant after ten weeks, it is assumed that the consultant agrees with the plan and the status of the plan is changed to 'locked down' on the system. We reviewed a sample of 50 consultants / SAS doctors across the three hospital sites to establish the number of job plans in place that had been fully signed-off. We identified the following findings: • 27/50 of the job plans were over a year old and overdue for review (9 RGH/PCH and 18 PoW). • 31/50 of the job plans had not been signed-off (12 RGH/PCH and 18 PoW). This included 20 (2 RGH/PCH and 18 PoW) that were greater than 10 weeks old, suggesting the process of locking the job plan down as assumed agreement, is not being consistently applied. More broadly, as at the end of August 2019, for all consultants (450) and SAS doctors (147) in the Health Board the data shows:	Sessions worked may not be sufficient to allow for adequate provision of the service. Consultant job plans may not reflect actual conditions or be developed by mutual consent.

• Only 14% of consultants (63) had a current (i.e. less than 12 months old) job plan that had been signed-off. • Only 26% of SAS doctors (39) had a current job plan that had been signed-off. • 70 consultants had no job plan at all (15.5%). • 45 SAS doctors had no job plan at all (31%).	
Recommendation	**Priority level**
1. The Health Board should develop an approach to ensure that all consultants and SAS doctors have an up to date job plan that is reviewed on an annual basis. In developing their approach, the Health Board should consult with consultants, SAS doctors and their line managers to identify the barriers that are currently preventing the timely completion and sign-off of job plans. 2. The Health Board should ensure that there are sufficient resources available so that job plans follow the 'lock down' process where the job plans are not formally signed-off in good time. The Approach should be consistently applied across all sites.	**High**

Management Response	Responsible Officer/ Deadline
1. Job planning does not necessarily require a face to face review if the plan agreed the previous year remains satisfactory. That said personal and organisational objectives need to be agreed for the year and can be signed off if non-contentious. 2. Job plan compliance is a standard agenda item at the Clinical Business Meeting (CBM) held with each directorate. The HR business partners are present at the CBMs to understand what if any barriers there are to job planning. The data is also reported through Finance Performance and Workforce Committee via the Board. 3. We acknowledge that there are many job plans which are out of date and / or not signed-off and this will be addressed by either through refreshed directorate training or Medical Director intervention. 4. Likewise, refreshed training is to be rolled out to Princess of Wales to ensure a consistent approach.	This will be monitored through the next annual cycle but refreshed training will take place November – March. Medical Director and delegated AMD working in collaboration with Paul Harrison – Head of Workforce Productivity and E-systems.

Finding 2 - Weekly number of sessions, activities and outcomes (Operating effectiveness)	Risk
The Welsh Government contract is based around a consultant working 10 sessions per week, with guidance suggesting a 7:3 split between DCC and SPA sessions. The Health Board guidance requires the reasons for additional sessions to be recorded in the e-job plan summary. We tested a sample of 70 job plans across the three hospital sites where there were variances from standard session allocation. For example, where there were more or less than 10 weekly sessions in total, or where there were more than 3 SPA sessions per week. We considered if the job plans had a documented reasonable justification for the variance away from the standard contract. Our testing identified the following issues: • While in most cases details of the additional sessions were recorded in the weekly activity detail, the reasons for the deviation were not recorded in the notes section. Where job plans were less than 10 sessions, it was difficult to determine the reasons why, as these were not recorded in the notes. • All 35 PoW job plans that we sampled predated the recent boundary change and so were aligned to deliver objectives and outcomes for the former Abertawe Bro Morgannwg University (ABMU) Health Board, which may not align with Health Board's objectives and desired outcomes.	Sessions worked may not be sufficient to allow for adequate provision of the service. Consultant job plans may not reflect actual conditions or be developed by mutual consent.

• 24/35 PoW job plans detail sessions to be undertaken at former ABMU sites such as Neath Port Talbot, Gorseinnon, Singleton and Morriston. It is unclear whether this activity has ceased or is ongoing. • For 32/70 SPA sessions within job plans there was insufficient detail in respect of the activities to be undertaken. • While Health Board outcomes were recorded for all of the job plans that we reviewed they were generic and very similar in nature with little detail or substance, and no clear link to the Health Board's IMTP objectives. • Guidance suggests that job plans should be linked to service objectives. 60/70 job plans reviewed did not include Service or Directorate objectives. Where these were recorded, they were vague and lacked detail. Activities and not objectives were included, such as 'undertake mortality reviews', 'respond to concerns'. • Rest breaks were factored into some timetables but not into all. Under EU legislation, it is compulsory for staff working more than 6 hours continuously to take a 30 minute break. However, the job planning guidance documentation does not offer any guidance on the approach to building breaks into job plans.	

Recommendation	Priority level
1. The notes section in the Allocate system should be used to record reasons for deviations from the standard Welsh Government consultant's contract and guidance. For example, where there are more or less than 10 weekly sessions in total, or there are more than 3 weekly SPA sessions. 2. A plan should be developed to ensure all PoW consultants and SAS doctors' job plans are reviewed and updated as soon as is practicably possible to align with the new Health Board's objectives. 3. Staff carrying out job plan reviews should ensure that all SPA activity is sufficiently detailed, that Health Board outcomes are linked to IMTP objectives, and that meaningful Service or Directorate outcomes are recorded in all job plans. This may be achieved by providing tailored training to staff responsible for conducting job plan meetings and reviews. 4. Health Board guidance should be provided detailing how breaks should be factored into timetables.	**High**
Management Response	**Responsible Officer/ Deadline**
1. Clinical sessions which exceed the contractual norm are relevant as determined by the business area, based on clinical requirements. This will also have implications for continuity and safety of clinical care. The additional sessions are also more cost effective for the Health Board as opposed to agency locums. The reasoning behind additional clinical sessions needs to be	Medical Director and nominated ADM together with Paul Harrison – Head of Workforce Productivity and E-systems

clear in the job plan. This will be emphasised as part of the updated training package.	Revised training guidance updated by November 2019 and rolled out thereafter, commencing with PoW.
2. As soon as the Health Board's operating model and subsequent objectives agreed, all Health Board objectives will need to be revisited through the annual job planning cycle. In the interim, existing job plans for Doctors in PoW will rollover into the next cycle.	Late 2020
3. The appropriate recording of SPA activity and linking to subsequent Health Board outcomes will be highlighted in the reviewed Health Board training material.	From November 2019 onwards
4. The Health Board is very clear about the rest break requirements under EWTD. The reason why breaks are not necessarily included is due to the flexibility required for the individual, as all job plans are variable and negotiated in accordance to service need. The requirement to take rest breaks will be further emphasised in the updated job planning training.	Revised training guidance updated by November 2019

Finding 3 – Clear personal outcomes within the job plan (Operating effectiveness)	Risk
For 40/70 job plans that we tested, no personal outcomes were included. Where recorded, personal outcomes appear brief and were generally activities, such as 'carry out professional development' and 'quality improvement lead for unit', rather than measurable outcomes. There was no link to the individual's annual appraisal objectives. Job planning guidance requires personal outcomes to be reviewed during the annual job planning review meeting, with an additional review undertaken by the Clinical Director and Directorate Manager on a six monthly basis. However, from our sample there was no evidence that six monthly review meetings were in place to assess progress against personal outcomes.	Sessions worked may not be sufficient to allow for adequate provision of the service. Consultant job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
Staff conducting job planning meetings and annual review meetings should ensure that all job plans include personal outcomes that are sufficiently detailed and measurable, and in line with personal outcomes and targets agreed as part of the annual review process. Progress against personal outcomes should be monitored and recorded in line with the Health Board's guidance.	**High**

Management Response	Responsible Officer/ Deadline
1. All CPD outcomes are noted, discussed and evaluated in the annual appraisal process as recorded on the Medical Appraisal Revalidation System, which is separate to the job planning process. As a result, there will not be a requirement for 'Personal Outcomes' to be completed on the e-job plan however this will need to be communicated to all Doctors as part of the revised job planning training material. 2. The updated training guidance should reinforce the requirement to monitor and record any measurable outcome. 3. The updated training guidance will clarify this point.	Medical Director and nominated AMD together with Paul Harrison – Head of Workforce Productivity and E-systems From November 2019

Finding 4 - Payments to consultants (Operating effectiveness)	Risk
The medical workforce team are responsible for notifying payroll when changes to job plans occur that affect a consultant's or SAS doctor's pay. We tested a sample of 20 consultant and SAS doctor job plans against the information held by payroll. The number of sessions paid did not match the number of sessions on the current job plans for 10/20. Our discussion with the Senior HR Manager Medical Workforce Team in relation to our testing identified: • 4/10 related to SAS doctors working in Anaesthetics that had paper based job plans. The information recorded on the Allocate system was different to the paper based plan, and pay is based on the paper plan. We have been informed that there are issues in using Allocate for this group of staff, so paper job plans are used. • For 1/10, changes were made to a job plan in February 2017 resulting in the plan reducing from 13 to 8 weekly sessions. The Medical Workforce Team do not process changes to job plans and notify payroll until the job plan has been signed-off. This plan had not been signed-off by the individual, but had been 'proxy' signed off under the Health Board's automatic sign-off procedure. This change had not been notified to payroll and at the time of our fieldwork it appears that the consultant was still being paid for 13 sessions. • In one instance we were informed that a consultant will be paid for 13 sessions despite their job plan showing 11.267 sessions. The variance was due to the consultant being paid for an additional session of 'AMD work'. However, there	Under or over payments may occur if job plan data is not accurately input to Payroll in a timely manner.

is no record of this additional session on the job plan or the spreadsheet record maintained by the Workforce Efficiency Officer. It is unclear what this payment relates to, and why it is being paid if it is not part of the job plan. • There were discrepancies in 4/10 PoW consultants that we tested. The Medical Workforce Team were unable to provide any explanation for the reasons behind the differences, as yet they do not have access to the historic information. A procedure for notifying the Medical Workforce Team and payroll when job plans for PoW consultants and SAS doctors have been agreed and signed-off has not yet been established.	
Recommendation	**Priority level**
1. An exercise should be undertaken to match the number of sessions from job plans to the payroll for all current consultants and SAS doctors to identify any discrepancies and any potential over or under payments to staff. All discrepancies should be investigated. 2. The current process for updating the payroll with changes to salaries arising from job plan changes should be reviewed to ensure it happens in a timely manner when a plan is signed-off or proxy signed-off. 3. A process should be established for notifying the payroll section of all new job plans and job plan changes for PoW based consultants and SAS doctors. 4. The job planning guidance refers to recording all information in relation to the plan in the e-job plan (Allocate), therefore where plans are created outside of the system, the Allocate system should be updated to reflect this.	**High**

Management Response	Responsible Officer/ Deadline
1. There has been a very robust process in place for some years which links signed-off job plans to changes to sessions paid. The Health Board will undertake an exercise comparing sessions off signed-off job plans with sessions paid.	Paul Harrison –Head of Workforce Productivity and E-systems November 2019
2. The process of notifying payroll when a job plan is signed off including proxy sign off, will be reviewed and standard operating procedures developed.	November 2019
3. PoW job plans and the process for sign-off and notifying Payroll follows exactly the same process as the rest of the LHB. As 2. Above.	November 2019
4. Further training will embed the use of e-job planning across the Health Board. Updated training document and training programme to be developed and rolled out.	April 2020

Finding 5 - Additional duty hours (Operating effectiveness)	Risk
We tested a sample of 15 'additional hours' payments made to eight consultants / SAS doctors. This was to ensure: there was reasonable justification for the additional hours; they had been approved in advance; the claim for payment was timely and appropriately authorised; and that the hours claimed did not clash with existing timetabled hours on the job plan. We identified the following during our testing: • None of the forms had been signed and dated by the Directorate Locum Booking Organiser or Authorising Consultant to evidence that the additional hours were approved in advance of being worked. • There were at least three different versions of the standard claim form in use which contained differing claimant declarations and data requirements. For example, some forms asked the question *'Does this replace SPA activity?*', whilst others did not. • 2/15 claims were submitted electronically via a spreadsheet which did not contain full details. For example, there were no start or finish times, no claimant declarations, no named approver or authoriser, and 'hours' columns were not added up increasing the risk of error. • It appears that for some of the hours claimed there was a clash with the existing job planned hours, potentially resulting in consultants and SAS doctors being paid twice for working the same hours. Some of the additional hours claimed were for shifts that continued on from a consultants timetabled hours or ended immediately prior to the normal	Under or over payments may occur.

start time the following day, which if worked would result in continuous duty of up to 36 hours. These clashes or continuous shifts potentially occurred for seven of the consultants / SAS doctors tested. In each case, there was no evidence that checks were carried out on the impact of additional hours on the consultants / SAS doctors scheduled timetable job planned hours. This could result in payments for additional hours being made whilst scheduled clinics or theatre sessions (for which consultants have already been paid) being cancelled.	
Recommendation	**Priority level**
1. Directorates should ensure that all 'Additional Duty' hours are authorised in advance of being worked. Authorisation should incorporate confirmation that a check has been carried out to ensure consultants are not already scheduled (according to the job plan) to work during proposed Additional Duty hours. Furthermore, the check should encompass ensuring that working the additional shift does not mean the consultant is then working 'back to back' shifts or cancelling DCC sessions to undertake the shift. 2. A single standard claim form should be used for ADH claims. Any system utilising electronic claim forms should contain the same data and claimant declarations as manual paper claim forms. Claimants should be required to confirm that they have not cancelled planned DCC sessions to undertake ADH.	**High**

Management Response	Responsible Officer/ Deadline
The Health Board are currently reviewing the ADH process with a view to driving all ADH arrangements through an e-system, as part of the development on an internal locum bank model. This model will address each of the recommendations noted.	Medical Director in conjunction with Paul Harrison –Head of Workforce Productivity and E-systems Scoping exercise to commence November 2019 with potential roll out by April 2020

Finding 6 - Spreadsheet record of job plans (Operating effectiveness)	Risk
A spreadsheet record is maintained by the Workforce Efficiency Officer that records the 'sign-off' status and other details of each job plan, such as the start date, review date, and the number of sessions. The spreadsheet is used to prepare job planning compliance statistics for directorates as the Allocate system has not got the functionality to record plans that are in a 'lock down' status, therefore meaningful reports and data cannot be generated from Allocate. We reviewed a sample of 50 job plans against the spreadsheet and identified the following: • The job plan 'status' was incorrectly recorded on the spreadsheet for 8/50 consultants / SAS doctors tested, with the spreadsheet showing some job plans as 'locked down', whereas on Allocate they were recorded as 'signed off'. • The review date recorded on the job plan differed to that recorded on the spreadsheet for 4/50 job plans. • The number of sessions recorded on an individual job plan did not agree to the number recorded on the spreadsheet for 5/50 of those that we tested. Given that this is the key source of data for the production of statistics, accuracy of the spreadsheet is essential.	Sessions worked may not be sufficient to allow for adequate provision of the service. Consultant job plans may not reflect actual conditions or be developed by mutual consent.

Recommendation	Priority level
The spreadsheet record of consultant job plans maintained by the Workforce Efficiency Officer should be reviewed for accuracy and correctly align to the data in the Allocate system.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The process of recording job plans on a separate spreadsheet will be further reviewed to reduce the requirement for manual intervention. If it is determined that the process should remain unchanged, a cross reference will be undertaken on an annual basis to ensure the Allocate system aligns with the spreadsheet.	Review of process November 2019 Paul Harrison –Head of Workforce Productivity and E-systems Annual audit – to be determined

Finding 7 - Commitment awards (Operating effectiveness)	Risk
The commitment award scheme is designed to allow consultants to be paid additional increments once they have reached the top of their scale and can demonstrate that they have a satisfactory job plan review in place. We note that there are no checks to ensure a satisfactory job plan is in place prior to awarding additional increments under this scheme. Our sample testing identified 8/10 consultants that were in receipt of additional increments but did not have a current or signed-off job plan in place.	Consultants may be paid additional increments they are not entitled to receive.
Recommendation	**Priority level**
Checks should be carried out to ensure consultants have a satisfactory job plan in place prior to being awarded additional increments under the Commitment Awards scheme.	**Medium**
Management Response	**Responsible Officer/ Deadline**
In the former Cwm Taf, Commitment Awards have historically been paid without checking if a satisfactory job plan was in place. In PoW this has always been done in line with the Amendment to the Consultant Contract in Wales. A revised process around Commitment Awards is being introduced and will be communicated across the Health Board. This process will ensure that consultants have a satisfactory job plan in place.	Paul Harrison –Head of Workforce Productivity and E-systems December 2019

Finding 8 - Input of job planning data to ESR (Control Design)	Risk
The manual input of job planning data into ESR is undertaken by the Workforce Efficiency Officer on receipt of an agreed, signed-off job plan or the proxy sign off of a plan. There is no interface between ESR and payroll, nor between Allocate and payroll so data is also manually input into the payroll system by another member of staff. Therefore, job planning data is available in the Allocate E-job Planning system, the spreadsheet tracker maintained by the Workforce Efficiency Officer, in ESR and in payroll. It was identified during the audit that the input of data to the ESR system was not up to date. It is unclear on the necessity to input data to the ESR system, given that it does not influence pay. The Health Board's Job Planning guidance does not make reference to the use of ESR to record job planning information.	Sessions worked may not be sufficient to allow for adequate provision of the service. Consultant job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
The requirement to manually input job planning data to the ESR system should be reviewed.	**Low**
Management Response	**Responsible Officer/ Deadline**
When the job plan recording functionality was introduced into ESR – and colleagues at Cwm Taf were actively involved in this – a deliberate decision was made that changes on the job planning side would not feed through automatically	Complete

into Payroll. The sole reason for recording job planning data in ESR is that all Wales reporting is done via ESR, particularly because not all NHS organisations in Wales use e Job Planning. There was a period during 2018/19 when job planning data were not being inputted into ESR. An exercise has been undertaken to correct this. No further action required.	

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.

Primary Care Cluster Plans

Internal Audit Report

2019/20

Cwm Taf Morgannwg University Health Board

October 2019

NHS Wales Shared Services Partnership

Audit & Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Committee:	Audit Committee

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

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

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the 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 & 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 Morgannwg University Health Board, no responsibility is taken by the Audit & 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 Primary Care cluster plans was completed in line with the 2019/20 Internal Audit Plan. The review sought to provide Cwm Taf Morgannwg University Health Board (the 'UHB' or the 'Health Board') with assurance regarding the process for the production and oversight of Primary Care cluster plans.

The Health Board initially had four Primary Care clusters (Cynon, Merthyr Tydfil, Taff Ely, Rhondda), with a cluster being defined as the bringing together of 'all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities.'

Primary Care services are often the first point of contact that a person has with the NHS in Wales. This can be through General Practices, pharmacy, dentistry or optometry services. The community services delivered through the clusters can include a wide range of staff such as community and district nurses, midwives, health visitors, mental health teams, health promotion teams, physiotherapists, occupational therapists, podiatrists, phlebotomists and paramedics.

Each cluster will have a three-year plan in place outlining the co-ordination of activities in its geographical area. Plans should be developed around nine strategic aims and detail the cluster's objectives under each of those aims. They outline who the key partners are in achieving listed objectives, target completion dates and the expected outcome for the patient of achieving the objective. Updates and RAG ratings are also provided on the progress that has already been made in achieving each objective.

Cluster plans should both shape and underpin the Health Board's integrated medium term plans (IMTPs) and embrace the key Health Board priorities for the forthcoming three years.

In April 2019, the Health Board took over responsibility for the provision of health care services to the population of Bridgend. As a consequence there are now three more clusters that fall under the remit of the larger Health Board (Bridgend East, West and North). As such, the Bridgend clusters have been considered in this review.

The relevant lead Executive for the assignment is the Director of Primary Community and Mental Health.

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 Primary Care cluster plans. The review sought to provide assurance to the Health Board's Audit Committee that risks material to achieving the system's objectives were managed appropriately.

The areas that the review sought to provide assurance on were:

- Alignment of cluster plans with Primary Care and Localities directorate IMTPs, the Health Board IMTP and Welsh Government objectives.
- The processes followed for the development of cluster plans, ensuring all relevant parties are involved and resultant plans are meaningful with achievable targets.
- Monitoring arrangements are in place at both a cluster level and directorate level to ensure the achievement of objectives.
- Governance arrangements are in place for the management of the clusters and any expenditure incurred in line with agreed objectives.
- Risks identified in the delivery of cluster plans are captured and there is a process to ensure relevant risks feed into the wider Health Board risk management process.

3. Associated Risks

The potential risks considered in this review were as follows:

- Welsh Government and Health Board objectives are not achieved where plans are not aligned or developed with due consideration.
- Budgets are exceeded where proper monitoring arrangements are not in place.
- The Health Board is exposed to un-necessary risks if process are not in place to identify and manage risk.

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 Primary Care cluster plans 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.

Our review of Primary Care cluster plans showed an alignment between the Primary Care and Localities Directorate and Health Board IMTPs, and Welsh Government Objectives. This supports the drive to further develop localities and transfer more services from secondary to primary care. However, in line with the Welsh Government's new Quality Assurance and Improvement Framework, new Cluster Group IMTPs were being developed during the course of our audit, which will replace the existing Primary Care cluster plans. In developing these plans it is important that there is clear alignment and links to directorate and Health Board objectives.

Our review of the cluster plan development process identified that good use was being made of data and information provided by Public Health Wales NHS Trust (PHW), and there was evidence of GP input into the planning process through the submission of their individual Practice Development Plans. However, there was no evidence that other cluster group stakeholders such as the Local Authority, Dentists, Pharmacists, Optometrists and third sector representatives had contributed directly to the plans.

We also identified that arrangements for the management of cluster group risks, and their potential escalation to the Health Board, were in the early stages of development and consequently were not currently effective.

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 cluster plans			✓	
2	Process for development of cluster plans		✓		
3	Monitoring and reporting arrangements				✓
4	Governance and finance arrangements			✓	
5	Risk 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 highlighted one issue that is classified as a weakness in the system control / design for Primary Care Cluster Plans.

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 Primary Care Cluster Plans.

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: Alignment of cluster plans with Primary Care and Localities directorate IMTPs, the Health Board IMTP and Welsh Government objectives.

We identified the following area of good practice:

- Priorities in the cluster plans broadly aligned to those in the directorate and Health Board IMTPs.

We did not identify any findings relating to this objective.

Objective 2: The processes followed for the development of cluster plans, ensuring all relevant parties are involved and resultant plans are meaningful with achievable targets.

We identified the following areas of good practice:

- Responsibility for coordinating and preparing cluster group plans had been specifically assigned to the Cluster Development Managers with leadership, direction and support from the Cluster Leads.
- A GP Practice Development Plan template has been provided to each GP Practice and its use has ensured the consistency of information provided to inform the cluster plan.

We identified the following findings:

- Due to poor attendance at cluster meeting by some stakeholder groups, there was no evidence that all stakeholders had input into the development of cluster plans, nor was there evidence that draft cluster plans were reviewed by respective cluster groups.
- Not all plans that we reviewed contained SMART objectives, and not all plans specifically assigned a lead with responsibility for achieving objectives.

Objective 3: Monitoring arrangements are in place at both a cluster level and directorate level to ensure the achievement of objectives.

We identified the following area of good practice:

- The Bridgend West cluster group recorded actions arising from cluster group meetings in an action log. This showed the action to be taken, the responsible lead and completion of the outstanding action. All other clusters undertook monitoring via the minutes of their meetings.

No findings were identified under this objective.

Objective 4: Governance arrangements are in place for the management of the clusters and any expenditure incurred in line with agreed objectives.

We identified the following area of good practice:

- Cluster group expenditure and budgets are monitored centrally by the Development Managers and Cluster Leads with input from Health Board's finance team, as appropriate. Clusters also undertake their own additional monitoring and cluster expenditure is a regular agenda item at Cluster Meetings.

We identified the following finding:

- All cluster group terms of reference were in need of updating.

Objective 5: Risks identified in the delivery of cluster plans are captured and there is a process to ensure relevant risks feed into the wider Health Board risk management process.

We identified the following finding:

- Risk management processes and procedures are not currently effective and in need of development across all of the cluster groups that we reviewed.

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**	**3**	**0**	**4**

Finding 1 - Risk management arrangements (Control design)	Risk
We reviewed the risk management arrangements at six cluster groups to ensure there were adequate processes and procedures in place for the identification, recording and monitoring of cluster group risks, and for the escalation of 'significant' risks to the Health Board. During our discussions with the Cluster Development Managers it was apparent that there are some risk registers and risk logs in place, however, risk management processes were generally not well established, and in some cases were in the very early stages of development. Our testing identified the following: • There was no standard risk assessment methodology in place. • There were no risk assessment forms in use. • Risks were not assessed for impact and likelihood on five of the six risk registers or logs that we reviewed, therefore the risk score is unknown. • There was no standard format risk register or risk log in use. • None of the risks on any of the risk registers or risk logs that we reviewed had an individual, unique risk identification number. • The date risks were added to the risk register or risk log was not recorded. • Responsibility for undertaking actions designed to mitigate risks was not recorded. • There was no evidence on any of the risk registers or logs that we reviewed that they had been updated.	Potential risks to the successful achievement of cluster plans are not being identified and mitigated against. The Health Board is exposed to unnecessary risks if processes are not in place to identify and manage risk.

• To date no risks had been escalated to the Health Board. There was no established approach for clusters to identify risks for escalation to the Health Board.	
Recommendation	**Priority level**
The Health Board should ensure that adequate risk management processes and procedures are put in place for all cluster groups. These should include: • A documented risk assessment methodology underpinned by a standard risk assessment form. • A standard risk register for use by all cluster groups. • Assigning each risk a unique risk reference and recording the date the risk was accepted onto the risk register. • Assigning a lead for each risk responsible for undertaking risk mitigating actions for that risk. • Ensuring risk registers are regularly reviewed and updated, and reviews are evidenced. • A process for identifying and escalating qualifying risks to the Health Board. It may also be beneficial for the Cluster Development Managers to undertake risk management training.	**High**

Management Response	Responsible Officer/ Deadline
We disagree that this is a HIGH Priority. Cluster Risks are very low however ToRs will be amended to reflect the requirement to assess and record risk appropriately. From a timescale point of view we will recommend that Clusters review the recommendations at the next Cluster Meeting and amend the ToRs as appropriate. ***Audit note**: We acknowledge the management response including management's view of our judgement of the priority level set against the recommendation. It is our view that, given the level of maturity of the risk management process within cluster groups and the work to be done, the high priority assessment was appropriate at the time of our fieldwork.*	Development Managers/Spring 2020

Finding 2 - Development of cluster plans (Operating effectiveness)	Risk
We held discussions with six of the seven Cluster Development Managers to review the process for developing the Primary Care Cluster Group Plans. There was good evidence of GP input to cluster group plans through the submission of their Practice Development Plans. However, there was no documentary evidence from other primary care providers such as dentists, pharmacists, optometrists and stakeholders such as the Local Authority, third sector and Public Health Wales. Our review of the minutes from the last year for the six cluster groups also identified very little discussion about the cluster group plans during the meetings or any input to the plan preparation process from these groups. We also identified: • The two Bridgend clusters reviewed held six meetings each over the last year. PHW was not represented at any of these meetings. The Local Authority was only represented at 4/12 of the meetings. • The minutes of the four meetings held by the Cynon cluster did not provide enough detail to determine which organisations were represented. • The Merthyr, Taff Ely and Rhondda cluster held 13 meetings in total over the last year. There was no Local Authority representative at any of these meetings, and the third sector representation was poor for the Rhondda cluster, with only 1/4 meetings attended.	Welsh Government and Health Board objectives are not achieved where plans are not aligned or developed with due consideration.

There appears to be some ambiguity around cluster group membership and those groups that are deemed as stakeholders as opposed to cluster members. The terms of reference that we reviewed does not make this distinction. Draft plans are submitted to the Primary and Localities Directorate Manager, but there is no timeframe for this, other than they need to be submitted in time for the development of the Primary Care directorate's IMTP. We also identified that feedback on plans was not sought or encouraged from patients or patient groups.	
Recommendation	**Priority level**
1. All members of the cluster groups should be encouraged to attend their cluster group meetings and have input to the development and refresh of their cluster group plans. The cluster groups should also encourage attendance at cluster group meetings by representatives from all stakeholder groups. 2. Cluster group plans should be subject to approval and sign-off from the cluster group during their meetings, prior to being submitted to the Health Board and published on the Health Board website. 3. Consideration should be given to feedback being provided to the Cluster Development Managers on their plans in order for best practice to be shared amongst the clusters.	**Medium**

Management Response	Responsible Officer/ Deadline
1. Cluster membership is not prescribed therefore attendance continues to be non-mandatory. Cluster Development Managers communicate details of meetings widely. Clusters cannot be held accountable for attendance. 2. Cluster Plans are approved at Cluster meetings however it is noted that this action should be clearly documented via ToR, Agenda's and Minutes of meetings. IMTPs have clearly documented participation requirements as set out in the revised GMS contract effective October 1st 2019. 3. Cluster Plans are shared at Cluster Leads Meetings however the introduction of IMTPs has clearly documented requirements for each Cluster GP Practice member.	Development Managers/December 2019 (for discussion/action at next Cluster Meeting as appropriate)

Finding 3 - Content of cluster plans (Operating effectiveness)	Risk
We reviewed all seven cluster plans and noted that there were two basic plan templates used, but these had been altered and not used consistently as clusters can choose their reporting style. The two templates related to the former Cwm Taf clusters and the former Abertawe Bro Morgannwg University Health Board (ABMUHB) clusters, which is inevitable during this period of transition. Within the 'Action Plan' section of the cluster plans, we identified: • The targets, aims and objectives were not always measurable or time-bound. In some cases the lead assigned responsible for implementation was not specific and just stated 'Health Board'. • All cluster plans included a RAG rating in the 'Action Plan' section but four did not include a key as to what each colour rating referred to. Of the three that did provide a key, there was consistency in the descriptors in two of the plans, with the third one using a different set of descriptors.	Welsh Government and Health Board objectives are not achieved where plans are not aligned or developed with due consideration.

Recommendation	Priority level
1. Cluster plans (or IMTPs) should include targets that are measurable and time-bound, and responsibility for achieving them should be specifically assigned within the cluster group. 2. A standard template should be used for all Cluster Group Plans. Where objectives and targets are RAG rated a key should be included in the plan.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. SMART Objectives will be set. 2. The introduction of IMTP's has addressed this item with a common template being adopted by all Clusters.	Development Managers/January 2020 Completed September 2019

Finding 4 – Cluster group terms of reference (Operating effectiveness)	Risk
We reviewed the terms of reference for six of the seven Cluster Groups and identified the following issues: • The terms of reference for the Bridgend clusters made several references to ABMUHB, (now Swansea Bay), for example compliance with ABMUHB Financial Regulations and Standing Orders. • The terms of reference for Cynon, Taff Ely and Rhondda cluster groups did not include the monitoring of cluster expenditure and ensuring the efficient use of financial resources. This is inconsistent with the other cluster groups. • The terms of reference for the three Bridgend clusters and the Merthyr cluster did not include the responsibility for the management of cluster group risks. This is inconsistent with the other cluster groups.	Welsh Government and Health Board objectives are not achieved where plans are not aligned or developed with due consideration.
Recommendation	**Priority level**
Consideration should be given to the impact of the boundary change and the period of transition to acknowledge and amend inconsistencies created by the processes and procedures followed by former ABMUHB colleagues. With consideration to any published Welsh Government guidance: 1. The terms of reference for the Bridgend cluster groups should be amended to ensure all references to ABMUHB are replaced with Cwm Taf Morgannwg UHB.	**Medium**

2. The terms of reference for the Cynon, Taff Ely and Merthyr cluster groups should be updated to ensure they include financial responsibility and the need to ensure efficient use of their budget in compliance with the Health Board's Financial Regulations and Standing Orders. 3. The terms of reference for the Bridgend and Merthyr cluster groups should be updated to include responsibility for the effective management of Cluster Group risks.	
Management Response	**Responsible Officer/ Deadline**
1. All ToRs will be reviewed to reflect CTMUHB. 2. All ToRs will be reviewed to ensure that clear financial controls are documented and Finances are formally reviewed throughout the year. 3. All ToRs will be reviewed to ensure that Risks are acknowledged, reported, assessed and reviewed.	Development Managers/Next Cluster Meeting Development Managers/Next Cluster Meeting Development Managers/Next Cluster Meeting

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.

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

Final Internal Audit Report

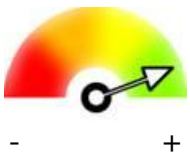
Cwm Taf Morgannwg University Health Board

2019/20

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Substantial Assurance

Prior year rating Substantial Assurance

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Appendix A Management Action Plan
Appendix B Summary of errors / anomalies amended prior to submission of reporting pack
Appendix C Assurance opinion and action plan risk rating

Review reference:	SSU_CTM_1920_04
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Fieldwork completion:	18 July 2019
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Auditor/s:	NWSSP A&A: Specialist Services Unit
Executive sign off	Ruth Treharne, Director of Planning & Performance
Distribution	Tim Burns, Assistant Director of Strategic & Operational Planning Paul Lewis, Head of Assets, Technical Services & Governance Gary Humphrey, Energy Manager Shane Evans, Head of Finance
Committee	Audit Committee

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

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

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1. Introduction and Background

The Carbon Reduction Commitment Energy Efficiency Scheme (CRC) is a UK Government initiative to reduce carbon dioxide (CO2) emissions from large and medium-sized organisations meeting certain qualification criteria.

Participation for these organisations is mandatory. The first phase of the scheme ran from April 2010 to the end March 2014. The second phase, which Health Boards joined, runs from 1st April 2014 to 31st March 2019.

The UK government announced in 2016 that the CRC energy efficiency scheme will be abolished following the 2018/19 compliance year. This is therefore the final audit of the Health Board's participation in the scheme.

Health Boards are required to submit their annual report by 31st July 2019.

2. Scope and Objectives

The assignment originates from the 2019/20 internal audit plan.

The overall objective of the review was to assess compliance with CRC requirements and guidance.

The scope of the audit review was limited to the following aspects:

- A review of the 2018/19 annual report (due for submission by 31 July 2019), to assess:
  - Accuracy of reported figures/totals;
  - Correct treatment of data including actuals/estimates, inclusions/exclusions etc.; and
  - Audit trail to supporting evidence;
- A review of the final position in terms of management of allowances; and
- Sufficiency of the Evidence Pack including document retention arrangements following closure of the scheme (required until March 2025).

This review drew on the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review were as follows:

- CRC guidance was not being followed;
- Reported data was inaccurate, which may incur financial penalties;
- Failure to sufficiently budget for, or achieve value for money from, the purchase of allowances; and
- Evidence pack was not appropriately maintained.

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.

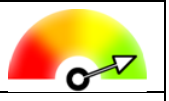
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the CRC Energy Efficiency Scheme is **Substantial Assurance**.

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.

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	Annual Report Data				✓
2	Purchase of Allowances				✓
3	Evidence Pack				✓

** 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 **0** issues that are classified as a weakness in the system control/design for managing the requirements of the CRC Scheme.

Operation of System/Controls

The findings from the review have highlighted **1** issue that is classified as weaknesses in the operation of the designed system/control for managing the requirements of the CRC Scheme.

6. Summary of Audit Findings

Annual Report Data



Data System

The UHB utilises the 'Team' energy management system; recording data input from self reads, invoices and supplier statements. Team includes a CRC module that generates the figures required for the annual CRC report.

Data Accuracy

The CRC procedural document remained extant to assist the individual officers charged with the delivery of the CRC annual report.

We sampled 88% of the reported electricity consumption figure and 92% of the reported gas consumption figure, confirming reconciliation to data taken from supplier statements and/or the Team system.

Fifteen sites [for both electricity and gas reported figures] were sampled and reconciled to working papers, with the majority of calculations correct.

However, some anomalies were noted due to discrepancies between supplier statements and supply as per monthly invoices [approved for payment]:

- Tonypandy Health Centre [electricity];
- Royal Glamorgan Hospital [self-supply electricity generation];
- Royal Glamorgan Hospital [gas];
- Prince Charles Hospital [gas]; and
- Dewi Sant Hospital [gas].

The impact of the anomalies resulted in an increase of 31kWh [electricity consumption] reported; an increase of 4,512kWh [self-supply electricity] reported and a decrease of 1,230,235kWh [gas consumption] reported. This being a cumulative decreased cost of £3,864 for the UHB [using the 2018/19 forecast sale allowance price]. These were discussed with the UHB and amended prior to submission of the evidence pack. Refer to **Appendix B** for details of the amendments **(Recommendation 1).**

Whilst the adjustments did not exceed the 5% threshold as per the CRC guidance[1], the UHB has been prudent in making the required amendments to the reported figures in advance of submission to the CRC Registry.

Estimated Data

The UHB initially reported 0.6% (*17/18: 0.3%*) of total electricity and 53% (*17/18: 25%*) of total gas consumption as estimated at the 2018/19 CRC report. As estimated supplies incur a 10% uplift by way of penalty for failing to hold accurate data, this would incur £7,710.59 (*17/18: £3,154.07*) in additional costs for the UHB (using the 2018/19 forecast sale allowance price).

The estimated data related to three sites [Hirwaun Medical Centre: electricity, East Glamorgan: gas and Royal Glamorgan Hospital: gas]. The decision to report two of these supplies (Hirwaun and Royal Glamorgan) as estimated was due to supplier issues being experienced with the meter readings. Both were assessed for accuracy of calculations and compliance with CRC guidance.

The supply for East Glamorgan was reported as 'estimated' upon the guidance of the annual supplier statement received. However, review of supporting documentation [monthly invoices approved for payment] noted that the number, and time-period between, actual reads adhered to the

[1] *You may be liable to a penalty for inaccurate reporting where any of the supplies or emissions reported differs by more than 5% from the supplies or emissions, which should have been reported, ignoring any estimation adjustments.*

definition for 'actual' classification as per the CRC guidance[2]. This was discussed with the UHB; and amended prior to submission of the evidence pack noting a saving of £2,646 to the UHB (using the 2018/19 forecast sale allowance) for not having to apply the 10% uplift.

Refer to **Appendix B** for details of the amendment **(Recommendation 1)**.

Corporate Responsibility Questions

The UHB were able to provide affirmatory answers to the four corporate responsibility questions, and had sufficient evidence to support these answers in accordance with the CRC guidance.

Report Submission

Calculated totals were uploaded to the CRC Registry, in advance of the deadline of 31 July 2019.

Annual Report Data: Conclusion

Noting the discrepancies between reported figures and supporting documentation, and acknowledging that the UHB took appropriate steps to review and amend the data, **substantial assurance** has therefore been determined in this section.

Purchase of Allowances .



As 2018/19 was the final year for CRC, participants were advised that it was important not to have excess allowances once the commitment for 2018/19 had been met; plus any previous commitment carried forward.

A UHB strategy had been developed for the forecast and/or buy-to-comply sales required. Forecast sales (at the lower rate) were the preferred option; with the intention to keep any later purchases to a minimum therefore ensuring a financially viable route of purchase for the UHB.

The UHB purchased 10,000 allowances in the forecast sale in April 2018 at a total cost of £172,000 i.e. taking advantage of the lower allowance rate offered through early purchase.

Post purchase, in addition to the allowances held from the previous year, the Health Board held a total of 15,752 allowances. Noting the 15,897 commitment for 2018/19, an additional 145 allowances were ordered in the buy to comply sale at a total cost of £2,653.50.

Confirmation was provided that the UHB had ordered the required 145 allowances in advance of 31 July 2019.

[2] *The **entire** annual supply of electricity of gas for a specific meter will be actual supply if, during the applicable compliance year (April to March) there are at least two actual meter readings at least half a year apart (for example, 183 days apart).*

This approach for closure yielded a reduction of £11,000 compared with the cost of having to purchase all allowances for the 2018/19 commitment in the buy-to-comply sale at year-end.

Noting the UHB's strategy for purchase of allowances, supported by comprehensive calculations and support of both energy and finance managers, **substantial assurance** has been determined in this section.

Evidence Pack



There was a comprehensive electronic evidence pack retained in accordance with CRC requirements. **Substantial assurance** has therefore been determined in this area.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations raised	-	-	1	**1**
Actioned since fieldwork	-	-	1	**1**
Number of recommendations to address	-	-	-	**-**

Finding: Accuracy of reported data	Risk
We sampled 88% of the total reported electricity consumption figure and 92% of the total reported gas consumption figure, confirming reconciliation to data taken from supplier statements and / or the Team system. However, some anomalies were noted due to discrepancies between supplier statements and supply as per monthly invoices [approved for payment] affecting the figures reported for: • Tonypandy Health Centre [electricity]: 44,902kWh as per supplier statement and 44,933kWh total supply as per paid invoices. Increase of 31kWh (0.01tCO2); • Royal Glamorgan Hospital [self-supply electricity]: 2,264,737kWh as per supplier statement and 2,269,249kWh as per paid invoices. Increase of 4,512kWh (1.27tCO2); • Royal Glamorgan Hospital [gas]: 15,860,655kWh as per supplier statement and 14,618,057kWh as per latest invoice [after credits and rebills]. Decrease of 1,242,598kWh (228.17tCO2) [*NB: classified as an estimated figure therefore 10% uplift to be applied: 250.98tCO2*]; and • Prince Charles Hospital [gas]: 1,667,589kWh as per supplier statement and 1,676,506kWh as per paid invoices. Increase of 8,917kWh (1.64tCO2)	Incorrect consumption figures reported; and risk of financial penalties if errors identified at external audits.

• Dewi Sant Hospital [gas]: 1,283,432 as per UHB readings in absence of supplier statement and 1,286,878kWh as per supplier statement subsequently received. Increase of 3,446kWh (0.63tC02). In addition to the above, the reported gas supply for East Glamorgan was 'estimated' However, review of supporting documentation [monthly invoices approved for payment] noted that the number and time-period between actual reads adhered to the definition for 'actual' classification as per the CRC guidance. The removal of the required 10% uplift for estimated supply provides a saving to the UHB of £2,646 [using the 2018/19 forecast sale allowance). Refer to **Appendix B** for details of the amendments.	
Recommendation 1	**Priority level**
Management should amend the evidence pack for the errors / anomalies reported **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed.	Amended prior to submission.

Appendix B: Summary of errors / anomalies amended prior to submission of evidence pack

Site / Meter	Supplier statement consumption	Reported consumption figure		Amended consumption figure		Explanation for amendment
	KwH	KwH	tCO2	KwH	tCO2	
Electricity – Appendix 1						
Tonypandy Health Centre [2199994600543]	44,933	44,902	13.69	44,933	13.70	Consumption reported did not reconcile to the year-end supplier statement received.
Self-supply electricity generation – Appendix 2						
Royal Glamorgan [CHP on site]	2,269,249	2,264,737	636.12	2,269,249	637.39	Consumption reported did not reconcile to the total of monthly statements received for electricity generated.
Gas – Appendix 3						
Prince Charles Hospital [21483210]	1,676,506	1,667,589	306.20	1,676,506	307.84	The total as per the supplier statement did not reconcile to the total supply as per invoices received.
East Glam [21110900]	8,377,025	8,377,025	1,692.01	8,377,025	1,538.19	Change from 'estimated' to 'actual as evidence of actual meter readings in compliance with CRC guidance. Amendments reduces total emissions by the 10% uplift applied for estimated emissions.

Site / Meter	Supplier statement consumption	Reported consumption figure		Amended consumption figure		Explanation for amendment
	KwH	KwH	tCO2	KwH	tCO2	
Royal Glamorgan [8818276705]	15,860,655	15,860,655	3,203.57	14,618,057	2,952.58	Supplier statement reported 21,895,135 kWh, which included 7,277,078 kWh relating to 'Gas not for heating' [Appendix 4 of reporting pack]. This consumption is correctly excluded from total CRC emissions. The amendment to reflect the most current supplier reported consumption [following credit notes and rebills issued post 31 March 2019] only affected the reported gas figure. Noting the ongoing work with the Health Board and the supplier, the reported consumption remained as estimated [10% uplift applied].
Dewi Sant [21109410]	1,286,878	1,283,432	235.66	1,286,878	236.30	Reported consumption based on internal readings. Supplier statement subsequently received with actual consumption recorded.

Appendix C: Audit Assurance Ratings

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

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

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

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

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit Committee Update – **Cwm Taf Morgannwg University Health Board**

Date issued: July 2019

Document reference: 123A2017



This document has been prepared as part of work performed in accordance with statutory functions.

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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	Our audit of the 2018-19 financial statements is complete. The accounts were certified by the Auditor General for Wales on 11 June (with an unqualified audit opinion) and laid with the National Assembly for Wales on 12 June. We do not propose to issue a separate Management Letter following this audit. Our audit work identified no significant matters to be reported to the Committee.	Work complete.
Charitable Funds Trustee Report and Accounts 2018-19	These financial statements are subject to an independent examination, rather than a full audit. Our examination is now largely complete, with only minor amendments proposed to the covering Trustee Report. The final Trustee Report and Accounts will be presented to the next Trustee Meeting for approval, allowing the accounts to be filed with the Charity Commission in advance of the 31 January 2020 deadline.	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
Work in progress				
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.	**Final Report at this Committee**	Ruth Treharne	October 2019
Joint review of Quality Governance arrangements within Cwm Taf Health Board	The overarching objective of this review is to examine whether Cwm Taf Morgannwg University Health Board's governance arrangements support the delivery of high quality, safe and effective services. The review examines the Health Board's overall corporate arrangements for quality governance, together with the quality governance arrangements within the surgical services directorate. Our work focuses predominantly on the Prince Charles and Royal Glamorgan Hospital sites.	**Report in draft**	Sharon Hopkins	January 2020

Orthopaedics: follow up review	This review will examine the progress made in the orthopaedic services since the 2015 all-Wales review. The work will assess whether Health Boards have effectively responded to the recommendations and areas for improvement. It will also seek to determine whether Health Boards are developing arrangements to help manage the demand on, and supply of, Orthopaedic services.	**Fieldwork stage**	John Palmer	January 2020
Structured Assessment 2019	Building on the previous years' work, this work will seek to describe the progress that is being made in embedding sound governance arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	**Fieldwork stage**	Sharon Hopkins	January 2020
Well Being of Future Generations (Wales) Act 2015	The work will consider the Health Board's overall corporate approach to applying the 'Sustainable Development Principle' and 'Five Ways of Working'. We will seek to examine one of the Health Board's well-being objectives in more detail, reviewing the steps that have been taken to achieve that objective. This work will inform will inform the report that the Auditor General must prepare for the National Assembly by May 2020.	**Drafting**	Kelechi Nnoaham	February 2020
Local Work Operating Theatres follow up	Follow up to our previous Operating Theatres work to check on progress against recommendations	**Fieldwork stage**	John Palmer	February 2020

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	
The Front Door to adult Social Care September 2019	The focus of our work has been to judge the effectiveness of this new 'front door' to social care, looking specifically at services for adults. Based on the findings of this audit, the Auditor General has concluded that councils are preventing social-care demand, but information, advice, assistance and not consistently effective
The Wellbeing of Young People September 2019	We looked at the welsh Government's work to support the well-being of young people in Wales. Well-being is a broad concept, so we have focused our work on five topic: youth homelessness; young adult caters; young parents; mental health; and skills and employability. We found that those working with young people are often frustrated they can't provide support in the ways they want to. At times staff feel they have to make decisions that are not in the young person's interests because of a lack of appropriate provision. Vulnerable young people find themselves having to join together the threads of fragmented service. We tried to understand why this is happening and found some common issues across different policy areas. Our reports on individual topic areas provide more detail.

Since the last Audit Committee, the Wales Audit Office has confirmed its plans to undertake a phase 2 review across a range of welsh Public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement.

Good Practice Exchange

Since the last Audit committee, we have held the following Good Practice Exchange (GPX) events. Materials are available via the links below.

Event/Product	Details
Future proofing public services September 2019	This webinar identified practical examples of services doing things differently to plan for the future and optimising benefits across public services in Wales. It looked at how we can recalibrate and think outside of our sector boundaries to achieve collective long-term change. We discussed how strategic and operational decision makers must balance the needs to today with the needs of tomorrow.
Making an Equal Wales a reality September 2019	This seminar looked at what public services are doing to contribute to a More Equal Wales. It was the starting point of knowledge sharing and knowledge gathering around this topic over the next two years for the Wales Audit Office. An all Wales study, the focus of which is yet to be determined, will follow in early spring, reporting in 2021 with a follow up event.

During the period up to December 2019, we plan to hold the following GPX seminars.

Event/Product	Details
How technology is enabling collaborative working across public services 17 October 24 October	The possibilities that digital technologies can provide are endless. This seminar will provide better understanding of tools available and how they can improve collaboration and help deliver smarter and higher quality services. This seminar will also share examples of organisations that are maximising the use of digital technology, enabling them to deliver services that promote independence (including through housing services), combat social isolation, promote carbon reduction and community wellbeing.

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Auditor General for Wales

Clinical coding follow-up review – **Cwm Taf University Health Board**

Audit year: 2018

Date issued: October 2019

Document reference: 1180A2019-20



This document has been prepared as part of work performed in accordance with statutory functions.

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The person who delivered the work was Emily Howell.

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Although accuracy has improved, coding completeness is an issue. There has been limited progress against our previous recommendations and coded data is not yet being used to its full potential.

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Summary Report

Introduction

1 Clinical coding involves the translation of written clinical information (such as a patient's diagnosis and treatment) into a code format. A clinical coder will analyse information about an episode of patient care and assign internationally recognised standardised codes[1].

2 Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used in many different systems and presented in different formats. It can be used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

3 Coding departments within Welsh NHS bodies are required to satisfy standards set by the Welsh Government on completeness and accuracy of coded data. Performance against these standards form part of NHS bodies' annual data quality and information governance reporting.

4 During 2014-15 the Auditor General reviewed the clinical coding arrangements in all relevant NHS bodies in Wales. That work pointed to several areas for improvement such as the accuracy of coding, the quality of medical records and engagement between coders, clinicians and medical records staff.

5 We also found that NHS bodies routinely saw clinical coding as a back-office role, often with little recognition of the specialist staff knowledge and understanding needed. In addition, not all health bodies understood the importance of clinical coding to their day to day business.

6 In January 2014, we reported our findings for Cwm Taf University Health Board (the Health Board) and concluded that 'While there had been a strong focus on improving the timeliness of management information, a range of weaknesses in the clinical coding arrangements and process were significantly reducing the accuracy of clinical coded data and backlogs in uncoded episodes were now increasing'. More specifically, we found that:

- clinical coding had a high profile at Board level, but coding needed more investment and there needed to be a greater focus on quality and accuracy;
- the quality of clinical coding was weakened by poor quality medical records, aspects of staff management and a lack of clinical engagement and audit processes; and
- clinical coded data was used appropriately and met the Welsh Government standards for 2012-13 but backlogs of uncoded episodes were increasing

[1] For diagnoses, the International Classification of Diseases 10th edition (ICD-10), and for treatment, the OPCS Classification of Interventions and Procedures version 4 (OPCS)

and there were significant problems with the accuracy of coding, the implications of which needed to be clearly identified to the Board.

7 We made several recommendations, which focused on:

- improving the management of medical records;
- strengthening the management of the clinical coding teams;
- strengthening engagement with medical staff; and
- building on the good engagement that already exists with the Board.

8 As part of the Auditor General's 2018 audit plan at Cwm Taf University Health Board, we examined the progress made in addressing the recommendations set out in the 2014 Review of Clinical Coding and any resulting improvement in clinical coding performance.

9 In undertaking this work, we:

- reviewed documentation, including reports to the board and committees;
- asked the Health Board to self-assess its progress so far;
- analysed clinical coding data sent to the Welsh Government;
- sought board member views[2] on their understanding of clinical coding; and
- interviewed staff to discuss progress, current issues and future challenges.

10 We summarise our findings in the following section. Appendix 1 provides specific commentary on progress against each of our previous recommendations.

Our findings

11 We conclude that although accuracy has improved, coding completeness is an issue. There has been limited progress against our previous recommendations and coded data is not yet being used to its full potential

Although accuracy has improved, the Health Board is not achieving is completeness target and has a significant coding backlog

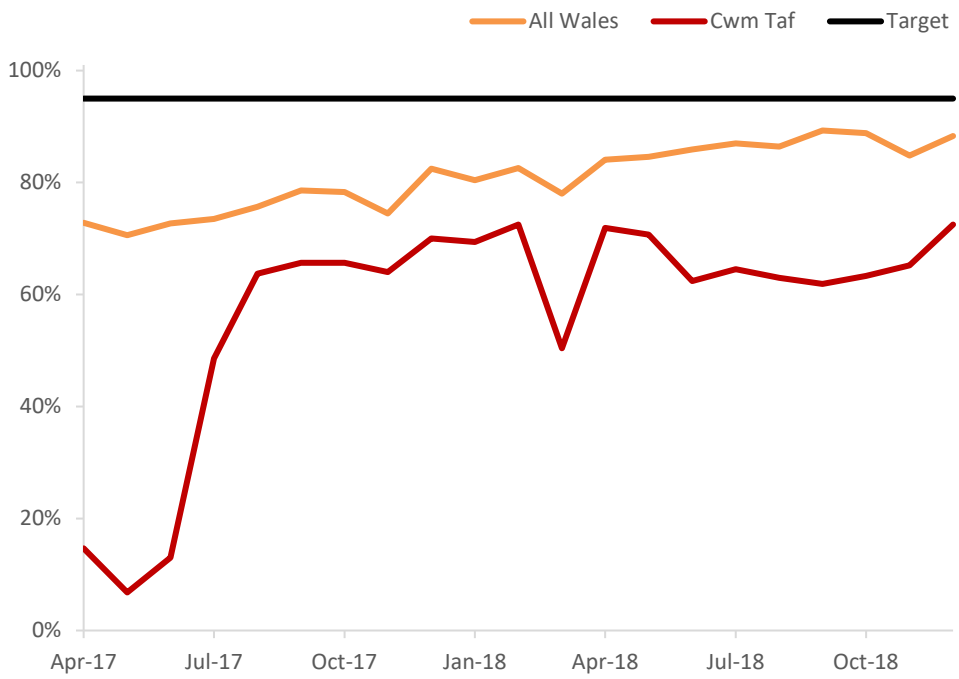
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

13 Each year, NHS bodies send data to the Welsh Government showing their performance against the Tier 1 target for **completeness**. The target is that 95 per cent of hospital episodes should have been coded within one month of the episode end date. NHS bodies need to meet this target monthly rather than at the end of

[2] A number of questions relating to clinical coding were included in the board member survey which formed part of our 2018 Structured Assessment work. A total of 15 responses out of a possible 22 responses were received.

each financial year which was previously the case. Based on this data, Exhibit 1 shows that Health Board's completeness has improved but is still not meeting the target, and is well below the all-Wales average.

Exhibit 1: percentage of all episodes coded within one month of the episode end date



Source: Wales Audit Office analysis of data sent to Welsh Government

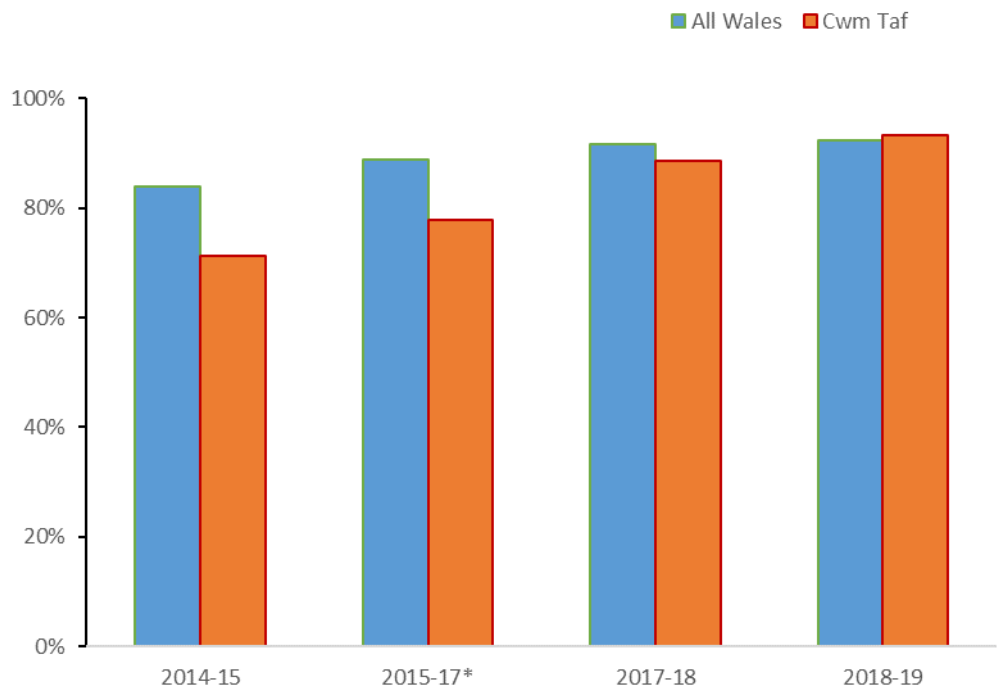
14 As part of our fieldwork, we requested the backlog position as at March 2018. The Health Board reported a small backlog of 1.87% Finished Consultant Episodes (FCE's), equating to 1,963 FCE's. Since then, the backlog position has deteriorated. The March 2019 performance report to the Board indicates a backlog position at December 2018 of 20,792 FCE's. The Health Board are employing agency and contract coders to assist in clearing the backlog as well as utilising overtime. However further funding will be required if the Health Board is to achieve the Welsh Government target. In addition, the Health Board has significant staffing pressures. There are high levels of sickness and absence, and retention of coders is still an issue.

15 Coding staff told us that conditions within the teams and recent issues with management and supervisory staff were having a detrimental effect on staff morale. This included concerns about the increase in workload from 30 to 40 case notes a day, a lack of training support and poor communication. The Health Board

is aware of these issues, and the teams have subsequently received some additional HR support including team building activities.

16 Each year, the NHS Wales Informatics Service (NWIS) Standards Team check the **accuracy** of clinical coding. They do this by reviewing a sample of coded episodes and checking the information against evidence within the patients' medical record to assess accuracy. NHS bodies are expected to show an annual improvement in their accuracy Based on this review, Exhibit 2 shows that Health Board's accuracy has improved and is above the Wales average.

Exhibit 2: percentage of episodes coded accurately



Source: Wales Audit Office analysis of data sent to Welsh Government

The full potential of coded data to inform service improvement is yet to be realised

17 Previously we found that not all NHS bodies understood the wider importance of clinical coding to their business and they were missing opportunities to use this information more extensively. For example, to plan and monitor services, where coding can be used to:

- assess volumes of patients following particular clinical pathways; and

- provide comparative activity data to evaluate productivity, quality and performance.

18 The profile that coding has within the Health Board is positive, with the Director of Planning and Performance continuing to act as a coding champion. The Health Board is using coded data to inform elements of service planning and improvements. For example, length of stay initiatives in relation to total knee replacements and work on caesarean section rates. However, the extent to which the data is being used is limited, which is recognised by the operational lead for coding.

19 The benefits of coded data to clinicians, for example, have not yet been realised. These include supporting medical revalidation and being able to identify trends in diseases or prevalence within the population.

The Health Board has made limited progress against our previous recommendations, with some key issues requiring attention

20 Exhibit 3 summarises the status of our 2014 recommendations.

Exhibit 3: progress status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
17	2	8	7	-

Source: Wales Audit Office

21 Our follow-up work found that the Health Board has made some progress against our 2014 recommendations, but many of our recommendations require further work to fully address them.

22 Since our 2014 review, there has been little change in the management of medical records. There continue to be issues with the quality of medical records which could affect the ability of clinical coders to undertake their role. The Health Records Committee was re-established at the time of our previous work, which was positive as it helped formalise engagement between coding and health records. However, this Committee was disbanded in August 2017 and no other arrangements were put in place. We are aware that the Health Board is undertaking a Clinical Audit review of the quality of documentation in case notes. This is due to report in March 2019.

23 As mentioned in paragraph 14, staffing levels within the coding department have been an issue for the Health Board. This was raised in a 2017 Internal Audit report, and again in a recent performance report to the Board. Whilst the Health Board has

taken positive steps to recruit trainee coders, the impact of these staff on productivity and subsequent achievement of the completeness target will take some time as they develop their skills.

24 To improve coding accuracy, the Health Board did support the supervisor at the time to attain the national clinical coding audit qualification which would have supported a local programme of coding audit. However, the member of staff has since left for a national role and the Health Board has been unable to find a course for the new supervisor to obtain the qualification. A performance development review process is in place to provide more informal feedback on issue, and feedback is given to staff. However, communication has been raised as an issue.

25 Clinical engagement has been described as the single most valuable resource to a coding department. In our previous report, we highlighted that there was limited clinical engagement in coding. Unfortunately, the team weren't unable to make much progress in this area due to staff capacity, and engagement with clinicians remains an issue.

26 Board engagement on coding issues continues to be good, and the quality and depth of the information on coding performance has improved since our last review. However, more could be done to inform the board on the wider importance of coding, the implications of poor clinical coding and the impact of the coding backlog. The full board survey results are available in Appendix 2.

Recommendations still outstanding

27 In undertaking this work, we have made one additional recommendation. This is set out in Exhibit 4. However, the Health Board also needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in Exhibit 5.

Exhibit 4: new recommendation

2019 Recommendation
Clinical Coding Resources
R1 Develop a training plan for Coders to support all levels of staff to develop and progress their careers.

Exhibit 5: recommendations still outstanding or overdue

2014 recommendations not yet complete
Management of Medical Records R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively support the clinical coding process. This should include: a) raising the importance of good quality medical records throughout the Health Board; b) clarifying roles and responsibilities for medical records amongst clinical support staff, such as ward clerks and medical secretaries, including filing and general record maintenance; c) developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving; d) reviewing the arrangements for filing result slips in medical records, taking into consideration the electronic reporting function of clinical systems; and e) putting steps in place to ensure that medical records are released to clinical coding teams as soon as possible after discharge.
Clinical Coding Resources R2 Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include: a) setting out a clear plan for succession planning of staff over the next five years, which will provide an opportunity for developing a clear career pathway and implementation of the accredited clinical coder qualification; b) providing support for members of the team to achieve the clinical coding auditor qualification, and the implementation of a local programme of clinical coding audits; c) reviewing the allocation of workload across the teams to ensure that clinical coding demand is evenly distributed; and d) encouraging whole team meetings which bring together all clinical coding staff from across the sites.
Engagement with Medical Staff R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include: a) raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings such as audit sessions; b) raising the awareness of the location of the clinical coding teams across the sites; and c) encouraging clinical coding staff to engage clinicians in the validation process and to visit clinical areas.

2014 recommendations not yet complete
Board Engagement R4 Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood. a) providing short briefing material which clearly sets out the implications of poor clinical coding (reflecting timeliness, completeness and accuracy) on key performance indicators; and b) ensuring that papers that are underpinned by clinical coding data, such as the performance management report, planning documents include a statement which sets out the robustness of the data.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 6: assessment of progress

Recommendation	Target date for implementation	Status	Summary of progress
Management of medical records R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include			
a) raising the importance of good quality medical records throughout the Health Board;	Not specified by the Health Board	Overdue	In 2014, we found that the quality of medical records across the Health Board was not of a good standard, with key information required for accurate clinical coding often missing or inappropriately filed. Our work has found that there continues to be issues with the quality of medical records within the Heath Board. In 2018, NWIS produced a report into clinical coding documentation. This review was undertaken as part of ongoing service improvement work to improve the quality of clinical coding data. The primary aim of this review was to assess the quality of the clinical documentation held within case notes. Overall administrative documentation was of good quality, but there were issues with loose paperwork and records being filed out of order. There were also issues with deceased notes and unplanned admissions. The quality of information for coders in the notes was poor. Only half of the clinical entries contained a diagnosis and of these, a third would be unable to be used for coding purposes. This report highlights that there are issues that need to be addressed by the Health Board.

Recommendation	Target date for implementation	Status	Summary of progress
			In our 2014 report, we noted the re-establishment of the Health Records Committee. The aim of this was to give the necessary focus to the quality of medical records to enable coders to code accurately. However, this Committee was disbanded in August 2017 and we are unaware of any new arrangements in place to monitor and ensure the quality of medical records.
b) clarifying roles and responsibilities for medical records amongst clinical support staff, such as ward clerks and medical secretaries, including filing and general record maintenance;	Not specified by the Health Board	Overdue	The review in 2014 highlighted that the medical records team had responsibility for setting up the record and ensuring that it is stored correctly. These arrangements have continued with medical records retaining responsibility for the movement and storage of files but not the contents. We are not aware of any specific work undertaken to clarify the role and responsibilities for medical records for any other staff.
c) developing a programme of routine audits of medical records to provide assurance that the quality of medical records is improving;	Not specified by the Health Board	In Progress	The quality of the patient record has a direct impact on the coders ability to undertake their role. As highlighted previously, work by NWIS into the quality of documentation highlighted concerns with loose paperwork, and the filing of deceased patient records. As part of the annual clinical audit and effectiveness plan, there is currently a Health Board wide audit of the quality of case notes. This audit is looking at documentation in case notes and is aligned to the health records committee, however this committee has been disbanded so we are unsure where the results of this audit are reviewed. The current audit plan shows that this audit was also undertaken last year but there is no record of the report. The results of the current audit are due for publication in March 2019.
d) reviewing the arrangements for filing result slips in medical records, taking into consideration the electronic reporting function of clinical systems; and	Not specified by the Health Board	Overdue	In 2014, we found that there were issues releasing medical records to the coding teams because of a backlog in results slips being filed. We recommended that this issue was resolved to ensure that medical records were freed up in a timely manner. However, we are

Recommendation	Target date for implementation	Status	Summary of progress
			not aware of any work being undertaken to address this issue, which continues to be problem.
e) putting steps in place to ensure that medical records are released to clinical coding teams as soon as possible after discharge.	Not specified by the Health Board	In progress	Our last review found that on average coders were getting access to medical records within 6 weeks of discharge, but some could take longer than three months to reach the department. Currently the Health Board is undertaking mapping work to understand where medical records are going. They recognise that coders need timely access to the records to meet the completeness target. Coders are working to get notes directly from the wards but sometimes they need to be requested from the central hub at Williamstown. There is a positive working relationship between medical records and coders and recognition why coders need timely access to the records. The hub is open 7 days a week and medical records allow contract coders to work directly from the hub on weekends to address the backlogs.
Clinical Coding Resources R2 Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include:			
a) setting out a clear plan for succession planning of staff over the next five years, which will provide an opportunity for developing a clear career pathway and implementation of the accredited clinical coder qualification;	April 2014	In progress	Staffing levels have been problematic for the coding teams. In our 2014 report we highlighted that there was a shortfall in the staffing establishment. In 2017, Internal Audit also raised concerns around the shortfall in staffing levels and the ability of the team to efficiently process the volume of hospital episodes and to meet the Welsh Government target. The Health Board has recognised this issue and has included a workforce plan in the strategy for the development for the clinical coding department. This strategy is set out clearly within the Integrated Medium-Term Plan for the Performance and Information Directorate.

Recommendation	Target date for implementation	Status	Summary of progress
			The Health Board has also introduced formal 'Annex U'[3] clinical coder training posts which are supported by a structured two-year internal training programme. These posts are trainee roles, and staff are appointed on an initial 24-month contract during which time the individual will be supported to work towards accreditation. The increase in trainee role however does not increase productivity significantly and can have a detrimental impact, as qualified coding staff need to support and check their work. Trainees also reported that they felt there was not enough support for them during their training to prepare them for exams. They also reported that there is no formal structure to the training or milestones to work towards and keep track of progress. The Health Board needs to consider how it will support all levels of staff to develop and progress their careers.
b) providing support for members of the team to achieve the clinical coding auditor qualification, and the implementation of a local programme of clinical coding audits;	March 2015	In progress	In 2014, we found that there was no local programme of clinical coding audit and a lack of a qualified clinical coding auditor within the Health Board meant that this could not be put in place. Since then, the Health Board did support an individual to attain the audit qualification, however they gained promotion into a national role soon after qualifying. The Health Board recognise this gap in their team, have been unable to find a coding course for them to achieve the qualification.
c) reviewing the allocation of workload across the teams to ensure that clinical coding demand is evenly distributed;	Not specified by the Health Board	In progress	The allocation of workload has remained consistent with our review in 2014. The Health Board has a general approach across the clinical coding teams at the two district general hospital sites. Coders take the records in chronological order to code regardless of the speciality to which the episode relates. Trainees rotate through the specialties to give them experience. However issues with allocation of workload have remained the same.

[3] Annex U is a NHS arrangement for trainees who are undertaking on the job training, Renumeration for new starters is a percentage of the Band 4 salary in line with Annex U Agenda for Change rules and once qualified they receive the full Band 4 salary.

Recommendation	Target date for implementation	Status	Summary of progress
d) encouraging whole team meetings which bring together all clinical coding staff from across the sites;	Not specified by the Health Board	Overdue	A whole team meeting for all sites was trialled. However, this meant that all staff were away from coding duties at the same time so it was stopped. Communication however has been identified as an issue. Staff are told they can raise any issues to managers, but the team feel that nothing is done about issues when they have raised them. The communication between management and the coding teams appears to be poor and morale is low. We understand that the Health Board have undertaken considerable work to improve communication, and there is executive awareness of the issues. Further work is needed to bring coders together and develop better trust between coders and management.
e) using opportunities presented by team meetings and individual appraisals to provide regular feedback to staff on issues raised through validation and audit; and	Not specified by the Health Board	In Progress	A PDR process is in place which gives a chance for feedback to staff on issues raised through routine validation. Additionally, there is regular information available on staff productivity through an electronic system which is used across the Health Board. However, there is currently no clinical coding qualified auditor within the team, so there is no regular casenote audits being undertaken.
f) monitor and manage high levels of productivity to ensure that the need for timeliness does not impact on the accuracy of clinical coding.	Not specified by the Health Board	Implemented	Regular information on staff productivity is available through CHKS reports which enables any areas of concern to be highlighted. Within coding, there is a recognised standard workload of 30 FCEs per day per full time coder, However the Health Board has decided to increase the workload target to 40 FCE's per day, which is 10 higher than the NWIS recommendation. The Health Board needs to be mindful that this does not negatively affect the quality of coding by putting staff under increased pressure to code more activity, although the NWIS accuracy scores have improved over time which is positive.
Engagement with medical staff R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:			

Recommendation	Target date for implementation	Status	Summary of progress
a) raising awareness of the clinical coding process adopted by the Health Board through training sessions for medical staff, as well as attendance at appropriate meetings such as audit sessions;	Not specified by the Health Board	In progress	In 2014, we highlighted there was limited clinical engagement in clinical coding. Since then, the Health Board has attempted to raise awareness of clinical coding by attending sessions some sessions clinical staff, for example recent engagement with ENT consultants but the extent to which this has happened has been limited and adhoc. Staff capacity within the coding team has been identified as the main reason.
b) raising the awareness of the location of the clinical coding teams across the sites; and	September 2014	Overdue	In response to our 2014 recommendation, it was identified that a departmental open day would be held to allow staff the opportunity to review coding systems, books and results. However, there has been no evidence to suggest this went ahead or any other initiatives to raise awareness of the location of the teams.
c) encouraging clinical coding staff to engage clinicians in the validation process and to visit clinical areas.	Not specified by the Health Board	Overdue	An identified model of good practice is to engage clinicians in the validation process. However, staff are reporting issues with accessing clinicians because it is time consuming and they often do not get a reply. The coding team however have established a single point of contact in ENT for coding queries, but this appears to be the only arrangement that is in place. Where engagement occurs elsewhere, this appears to be reactive to concerns about the quality of coding. For example, cardiology approached the coding team when they were receiving data which did not match what they were expecting. This discussion has however provided an opportunity to raise the importance of good quality case notes to support the coding process.
Board engagement R4 Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood.			
a) providing short briefing material which clearly sets out the implications of poor clinical coding (reflecting timeliness, completeness	Not specified by the Health Board	In progress	The Health Board has maintained its surveillance of its coding performance, and both completeness and accuracy feature as part of the Health Board's key performance indicators which are

Recommendation	Target date for implementation	Status	Summary of progress
and accuracy) on key performance indicators;			reported to Board. The detail and benchmarking information in these have improved since our last review. The information highlights the backlog and the actions being taken. However, the report does not explicitly highlight the impact the backlog has on the quality of data. The results from our board member survey identified that 87% of those responding said they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information. Since our previous work, the Health Board has had considerable churn of Independent Members who may benefit from training on clinical coding.
b) ensuring that papers that are underpinned by clinical coding data, such as the performance management report, planning documents include a statement which sets out the robustness of the data; and	Not specified by the Health Board	Overdue	In our original review there were regular performance reports to the Board in respect of coding. At the time these reports were highlighting significant backlogs in coding activity. The levels of backlog were not dissimilar to the current reported position in March 2019. At the time, the risks to other reported performance data because of clinical coding backlogs was identified as an extreme risk and featured in the Health Board's corporate risk register. Clinical coding does not currently feature on the Health Board corporate risk register, nor is there reference in any papers that rely on clinical coding data to the impact that the backlog, for example, can have on the quality of data.
c) alongside the clinical coding performance for the rolling 12-month period, providing the total level of uncoded activity which is outstanding from previous periods.	April 2014	Implemented	There have been considerable improvements to the level of information included in the performance reports produced by the Health Board since our original review. Detailed exception reports are produced which show the current, historical and comparative benchmark position against other Health Boards in Wales. The total level of uncoded activity is now included on the performance report which makes it clearer to see for all periods.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from 15 of the board members in the Health Board.
The breakdown of responses is set out below.

Exhibit 7: rate of satisfaction with aspects of coding

	How satisfied are you with the information you receive on the robustness of clinical coding arrangements in your organisation?		How satisfied are you that your organisation is doing enough to make sure that clinical coding arrangements are robust?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Completely satisfied	-	6	-	5
Satisfied	8	34	8	40
Neither satisfied nor dissatisfied	7	46	7	46
Dissatisfied	-	10	-	4
Completely dissatisfied	-	-	-	1
Total	**15**	**96**	**15**	**96**

Exhibit 8: rate of awareness of factors affecting the robustness of clinical coding

	How aware are you of the factors which can affect the robustness of clinical coding arrangements in your organisation?	
	This Health Board	**All Wales**
Full awareness	6	26
Some awareness	5	50
Limited awareness	3	17
No awareness	1	3
Total	**15**	**96**

Exhibit 9: level of concern and helpfulness of training

	Are you concerned that your organisation too readily attributes under performance against key indicators to problems with clinical coding?		Would you find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Yes	1	8	13	77
No	14	84	2	19
Total	**15**	**92**	**15**	**96**

Exhibit 10: additional comments provided by respondents from the Health Board

- I feel some of the questions could have been framed better in order to consider the role of Board committees. I suspect you will get different responses from those who are on a Committee that considers Clinical Coding to those Board Members who are not. I think there also needs to be caution in interpretation of the responses as its important the Committees of the Board discharge their delegated functions and assure the Board or not, as there is a danger the latest audit focus becomes a Board level agenda item for the wrong reasons and it may not be a priority to feature on the business of the Board.
- I work very closely with clinical coding colleagues as it impacts on national audit reports which I lead on.
- It would be more beneficial to have a fully digital data capture to minimise the risk of human error particularly when dealing with patients with multiple conditions.
- Coding is a specialist activity and coders require training and motivation. There needs to be a national campaign to train coders to a national standard and for Boards to acknowledge the importance of coding as an informer of clinical practice and policy development.

Appendix 3

Management response

Report title: Clinical Coding Follow-up Review

Completion date: March 2019

Document reference: 1180A2019-20

2019 Recommendation

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Clinical Coding Resources** Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity.	To develop clear career pathways and support clear succession planning	Yes	Yes	The plan to support these changes are included in the Departmental IMTP 2019/20-2021/22	March 2020	Assistant Director of Performance and Information

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AUDIT COMMITTEE FORWARD WORK PLAN 2019/20

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
15 July 2019 9am Ynysmeurig House	Minutes Action Log Declarations of Interest Forward Work Programme Charitable Fund Balances last quarter Audit Recommendation Tracker Report Losses and special payments Local Counter Fraud update (Closed) Head of Internal Audit Report Internal Audit Reports (any limited or no assurance reports require lead director presence) WAO Progress Report and any related external audit reviews WAO Audit Reports (as per Annual Audit Plan 2018/19) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP) Clinical Audit and Effectiveness 2019/20 (and summary against 2018/9 plan) ~~Board Assurance Framework~~ (for Board Development discussion)	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses

Meeting	Standing items/Governance	Internal control and risk management	Part II meeting – hosted bodies	Internal control and risk management
28 October 2019 9am Ynysmeurig House	Minutes Action Log Declarations of Interest Forward Work Programme Charitable Fund Balances last quarter Audit Recommendation Tracker Report Losses and special payments – review of plans and priorities Local Counter Fraud update (Closed) Head of Internal Audit Report Internal Audit Reports (any limited or no assurance reports require lead director presence) WAO Progress Report and any related external audit reviews WAO Audit Reports (as per Annual Audit Plan 2018/19) Items for information (not normally for discussion) Referrals to other committees Any other urgent business	Procurements and Scheme of Delegation Report (to include an update on actions and progress relating to PSPP) Board Assurance Framework Review of internal communications for LCFS (from April 2019) Len Couzens	Minutes Action Log Declarations of Interest	Audit Recommendation tracker report WHSSC CRAF update EASC Risk Register Update Receipt of any hosted body internal / external audit report and management responses

Additional items – January 2020 Review of the resource allocation to the Counter Fraud Service (Director of Finance)