Archwilydd Cyffredinol Cymru
Auditor General for Wales

Governance in the NHS in Wales
Memorandum for the Public
Accounts Committee

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared and published this report in accordance with the Government of Wales Act 1998.

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Introduction

1   This memorandum has been prepared following the Public Accounts Committee's request for information about the governance arrangements in NHS Wales. The request was made as part of the Committee's consideration of evidence into the governance arrangements at Betsi Cadwaladr University Health Board.

2   The governance arrangements that relate to NHS Wales are set out in an e-governance manual[1] and in a number of associated documents that provide directions, instructions and guidance within the wider policy context of NHS Wales.

3   The memorandum has drawn on this information to provide an overview of the governance arrangements that relate to NHS Wales. It is in three parts:

a   Part 1 sets out the context and landscape in which governance arrangements in the NHS in Wales operates;

b   Part 2 describes the key components of the governance arrangements in the NHS in Wales; and

c   Part 3 draws upon audit findings from across Wales to provide some high-level commentary on how the governance arrangements within NHS bodies appear to be working in practice.

1   http://www.wales.nhs.uk/governance-emanual/home

Part 1

The governance of NHS Wales in context

Organisation of health services in Wales

1.1   There is a complex network of organisations and entities involved in delivering NHS services in Wales, and in holding NHS bodies to account. There are seven Health Boards whose principal function is ensuring the effective planning and delivery of healthcare in their locality, and three NHS Trusts who have specialist all-Wales functions. Exhibit 1 provides a schematic summary of the main organisations involved, the flows of funding and the lines of accountability.

1.2   Exhibit 1 lists the numerous organisations and activities that are 'hosted' by either a Health Board or NHS Trust but are tasked with delivering or planning services at an all-Wales level. Hosted bodies are legally part of, and are accounted for, within their hosting organisation but they are outside of the host's usual management arrangements and are not simply 'divisions' within health bodies.

1.3   The scale of operation of hosted organisations within NHS Wales varies considerably and some fulfil significant roles. The most notable of these are described below.

Welsh Health Specialised Services Committee (WHSSC)

1.4   The WHSSC is a joint committee of the health boards in Wales and is hosted by Cwm Taf University Health Board[2]. The WHSSC receives money from the other health boards and its main function is to plan and secure tertiary services such as specialist heart surgery, mental health, renal neuroscience and neonatal services for the population of Wales. In 2013-14 the Committee had a budget of £609 million.

1.5   The joint committee is not a separate legal entity to the health boards. Whilst the committee acts on behalf of the health boards, the duty on individual health boards remains, and they are ultimately accountable for the provision of specialised and tertiary services for residents within their area. The joint committee reports to each health board on its activities. The joint committee is also accountable to the Welsh Government through the NHS performance management system.

1.6   The chief executive of Cwm Taf University Health Board is the Accountable Officer for WHSSC. Membership of the joint committee consists of the health board chief executives, a chair appointed by the Welsh Ministers, a vice chair, two non-officer members and four officer members[3] employed by the hosting health board. The chief executives of the three NHS Trusts are non-voting associate members of the joint committee.

1.7   The core membership of the joint committee is the health board and trust chief executives. This represents a complicated arrangement where the health boards and trusts are effectively taking decisions about the commissioning of specialist services when these organisations are also the providers of these services.

2   The Welsh Health Specialised Services Committee (Wales) Regulations 2009, 17 December 2009.
3   The vice chair and two non-officer members are appointed by the joint committee from the pool of existing non-officer members of the health boards.

Exhibit 1 – Diagram of the main entities involved in NHS Wales governance

National Assembly for Wales	
Welsh Government	
Department of Health and Social Services	
Integrated Delivery Board	

Funding
Accountability
Hosting relationship

Welsh Ambulance Services NHS Trust

This trust provides emergency ambulance services across Wales as well as non-urgent patient transport and a health courier service.

Velindre NHS Trust

Velindre has two major divisions; Velindre Cancer Centre and the Welsh Blood Services. It also hosts a number of 'hosted bodies'

Public Health Wales NHS Trust (PHW)

PHW provides independent public health advice and services to protect and improve the health and wellbeing of the population of Wales.

Local Health Boards

There are seven of these organisations.

Their commissioning functions include:
- Planning and purchasing services
- Setting quality requirements and monitoring performance
- Supporting improvement and intervening if needed.

Their service provider functions include:
- Delivering healthcare services
- Developing an internal quality system
- Developing staff
- Continual improvement and learning from mistakes

Hosted bodies

These bodies sit within hosting organisations and deliver/plan services at an all-Wales level:

Welsh Health Specialised Services Committee
Emergency Ambulance Services Committee
NHS Wales Shared Services Partnership
NHS Wales Informatics Service
National Specialist Advisory Group for Cancer
National Collaborating Centre for Cancer
National Institute for Social Care and Health Research Clinical Research Centre
The NHS Centre for Equality and Human Rights
Prescription Pricing Authority

Local providers

[GPs, Dentists, Opticians, Pharmacists]

Source: Wales Audit Office research

1.8 The chair is directly accountable to the Minister for Health and Social Services for their personal performance. The chair is also accountable to the health boards in relation to the functions of the joint committee. Finally, the chair is accountable to the hosting health board in respect of the WHSSC's compliance with the governance and operating framework.

1.9 The governance frameworks covering WHSSC include a Memorandum of Agreement that defines the roles of the health boards' Accountable Officers, a hosting agreement with Cwm Taf, standing orders (that form a schedule to each of the health boards' own standing orders), a schedule of reservation and delegation of powers and standing financial instructions.

1.10 At the time of preparing this memorandum, a review of the governance systems relating to WHSSC had been commissioned, with a focus on:

    a   the decision-making processes that operate through the current governance model;

    b   each element of WHSSC governance on its own terms including the Joint Committee;

    c   how WHSSC should best fit in the Welsh Government three-year Integrated Medium Term Planning processes and the Performance Management Framework; and

    d   how the Local Health Boards could exercise their WHSSC responsibilities more effectively as both commissioner and provider.

1.11 The review is due to completed by the end of 2014.

NHS Wales Shared Services Partnership (NWSSP)

1.12 The NWSSP is hosted by Velindre NHS Trust. It provides a range of services based across Wales which support NHS Wales in relation to procurement, employment, counter fraud, primary care information and administration, audit and assurance, facilities services, legal and risk services, Welsh Risk Pool Services and workforce, education and development services.

1.13 An NWSSP Committee determines the policy and strategy, and monitors the delivery of Shared Services. The Committee is made up of representatives of NHS bodies across Wales and senior Shared Services staff. The Director of Shared Services is responsible for exercising the functions delegated to him by the Local Health Boards and Trusts in accordance with the policy set by the NWSSP Committee. The Director is also accountable to the Welsh Government's Director General for Health and Social Services.

1.14 Within Velindre NHS Trust there is a single Audit Committee, and as part of the hosting arrangements, this Committee will meet to specifically consider shared-services matters at certain points in the year.

NHS Wales Informatics Service (NWIS)

1.15   The NWIS is hosted by Velindre NHS Trust, was established in 2010 and has responsibility for the design, deployment and management of national IT systems within NHS Wales. NWIS has a national remit to support NHS Wales through the use of national ICT technologies by doing things 'once for Wales'. It is also involved in delivering operational ICT services, information management and making better use of IT skills and resources across Wales.

1.16   The NWIS was formed by bringing together the following organisations/ programmes: Business Services Centre, Corporate Health Information Programme, Health Solutions Wales, Informing Healthcare, Information Services Division and Primary Care Informatics Programme.

1.17   The NWIS is headed by a Director who is also the Chief Information Officer for Health within the Welsh Government. The Director of NWIS is also bound by an accountability agreement for governance compliance with the Velindre NHS Trust Chief Executive.

Emergency Ambulance Services Committee (EASC)

1.18   This is a joint committee of the health boards in Wales, established on 1 April 2014[4] to jointly plan and secure emergency ambulance services in Wales. The Committee met for the first time on 11 April 2014 and hence the governance arrangements are still in their infancy.

1.19   Cwm Taf University Health Board hosts the joint committee, which took over the emergency ambulance-related duties that were previously provided by the Welsh Health Specialised Services Committee.

1.20   The Committee comprises a Chair (appointed by the Minister), Vice Chair, the chief executives of the health boards and the Chief Ambulance Services Commissioner. The chief executives of NHS trusts are associate members.

1.21   The Chief Ambulance Services Commissioner leads a commissioning team to secure and monitor performance of emergency ambulance services. The team is employed by the hosting organisation. The standing orders for the Committee are agreed by the health boards and form a schedule within each of the health boards' own standing orders.

1.22   The other hosted bodies in NHS Wales are:

   a   the National Advisory Group for Cancer;

   b   the National Collaborating Centre for Cancer; and

   c   the National Institute for Social Care and Health Research Clinical Research Centre.

1.23   More information on these bodies is provided in Appendix 1.

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4   Emergency Ambulance Services Committee (Wales) Regulations 2014, No. 566 (W. 67)

The statutory framework

1.24   The 'statutory' framework for NHS Wales comprises three core components:

   a   Primary Legislation: setting out the statutory powers and duties of the NHS;

   b   Statutory Instruments: detailing the functions of NHS bodies; and

   c   Standing Orders: providing the rules by which health boards and trusts work and make decisions.

Primary legislation

1.25   Most of the business of NHS bodies will be conducted in accordance with powers contained in the NHS (Wales) Act 2006[5] and the arrangements set out within the relevant Constitution, Membership and Procedures Regulations[6]. All NHS bodies in Wales must also operate within the wider legislative framework governing all UK organisations.

1.26   The NHS (Wales) Act 2006 consolidates a range of regulatory requirements relating to the promotion and provision of the health service in Wales. It sets out Welsh Ministers' duty to promote health services and the powers to help them do so including establishing NHS bodies, directing how the bodies should perform their functions and intervening when things go wrong.

1.27   The 2009 NHS reforms in Wales, which saw the creation of new integrated health boards were enacted using the powers conferred upon Welsh Ministers in the NHS (Wales) 2006 Act, and did not need fresh primary legislation.

1.28   Section 33 of the NHS (Wales) Act 2006 enables Health Boards, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS and health related functions as specified in the Regulations. These arrangements can only be made if they fulfil the objectives set out in the health improvement plan of the NHS body, are likely to lead to an improvement in the way current services are provided, and the partners have consulted jointly with all affected parties.

1.29   More recently, the NHS Finance (Wales) Act 2014 has introduced a more flexible finance regime. It provides a new legal financial duty for Local Health Boards to break even over a rolling three financial years rather than each and every year. The Act allows Local Health Boards to focus their service planning, workforce and financial decisions and implementation over a longer, more manageable, period and moves away from a regime which encourages short-term decision making around the financial year. The financial flexibilities are, however, contingent upon the ability of NHS bodies to prepare suitably robust integrated medium-term plans, and the formal approval of those plans by Welsh Ministers.

5   http://www.legislation.gov.uk/ukpga/2006/42/section/33
6   http://www.wales.nhs.uk/governance-emanual/regulations-constitution-membership-and-

Statutory instruments, standing orders and other directions

1.30   Statutory instruments are created by the executive branch of government and set out the functions of NHS bodies in Wales. There are currently some 26 statutory instruments[7] covering NHS bodies and Community Health Councils in Wales.

1.31   Standing orders are the rules by which NHS bodies operate and make decisions. Standing orders for NHS bodies in Wales should be based upon the models determined by the Welsh Government[8].

1.32   The NHS (Wales) Act 2006 allows Ministers to give directions and instructions to health bodies. In addition to statutory instruments, these directions and instructions can take the form of:

   a   *Welsh Health Circulars* – these are now being re-introduced (after having been replaced in recent years by Ministerial Letters) as a mechanism for the Minister to issue guidance to NHS bodies on a wide range of issues; and

   b   *Accountable Officer Letters* – these are used to provide specific direction or advice on issues of accountability, regularity and propriety and annual accounting exercises.

1.33   NHS bodies have a legal duty to comply with any direction issued by Welsh Ministers. Instruction or guidance issued through a Ministerial Letter or a Welsh Health Circular also has the same legal standing as a direction, and should be treated as mandatory.

1.34   The Welsh Government's Department for Health and Social Services may also issue instructions and guidance to NHS bodies. Instructions may be specifically to support a key policy requirement, or provide good practice guidance on a particular aspect of business.

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7   http://www.wales.nhs.uk/governance-emanual/secondary-legislation
8   http://www.wales.nhs.uk/governance-emanual/standing-orders

Setting out what is expected

Principles and core values

1.35 The NHS e-governance manual identifies a number of core values for the NHS in Wales, namely:

    a   putting quality and safety above all else;

    b   integrating improvement into everyday working;

    c   focusing on prevention, health improvement and inequality;

    d   working in partnership; and

    e   investing in staff.

1.36 These core values are designed to support good governance and the achievement of high standards of care. Alongside these, specific codes of Conduct for Board Members and NHS Managers[9] have been developed which incorporate the Seven Principles of Public Life ('the Nolan Principles'). In addition, there are policies on specific areas, including whistleblowing and compromise agreements described within 'Openness and Business Conduct'[10].

Standards for services

1.37 *Doing Well, Doing Better – Standards for Health Services in Wales*[11] contains 26 standards that set out the requirements of all services in all settings in the NHS in Wales. These standards were introduced in 2010, replacing the previous ones launched in 2005.

1.38 The standards framework is underpinned by supporting guidance for individual standards and 'How to Guides' which give practical advice on how to implement them. A Governance and Accountability module provides NHS Boards with a framework to monitor performance against the standards. This largely takes the form of self-assessment against maturity matrix descriptions.

1.39 At the time of preparing this briefing, the Welsh Government was undertaking a review of the Standards for Health Services in Wales.

1.40 The Standards for Health Services in Wales sit alongside a number of other mechanisms that set out what is required in delivering services to patients. These include a suite of Delivery Plans for specific conditions such as heart disease, stroke, diabetes, respiratory health and eye health amongst others. These plans typically set out the key actions that need to be taken to improve healthcare outcomes for patients. Many of these Delivery Plans have replaced National Service Frameworks that had previously been developed for these conditions.

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9   http://www.wales.nhs.uk/governance-emanual/codes-of-conduct
10   http://www.wales.nhs.uk/governance-emanual/openness-and-business-conduct
11   Welsh Government, *Doing Well, Doing Better – Standards for Health Services in Wales,* 1 April 2010.

1.41   Other key mechanisms for setting out patient-care requirements comprise:

   a   The range of professional standards and regulations that apply to specific
        health professions and services.

   b   *Fundamentals of Care*[12] guidance which was produced by the Welsh
        Government in 2003 and contains a set of indicators that cover fundamental
        aspects of quality that are important to anyone receiving health or social care.

   c   The National Institute for Health and Care Excellence (NICE) standards,
        guidance and advice on a wide range of health and care service areas in
        Wales.

   d   The *Quality and Outcomes Framework* for general practitioners is a voluntary
        framework that aims to reward GPs for providing good practice. Practices are
        awarded points for providing evidence of good practice coverings four domains
        of general practice: clinical, organisational, patient experience and additional
        services.

The operating environment

Strategic policy framework

1.42   There is a comprehensive and growing suite of policy documentation that sets out
        the strategic direction and intent for the NHS in Wales. *Together for Health*[13] is the
        five-year strategic vision for the NHS in Wales. It outlines the challenges facing
        the health service and the actions necessary to ensure it is capable of world-class
        performance. The main commitments in the vision are:

   a   service modernisation, including more care provided closer to home and
        specialist 'centres of excellence';

   b   addressing health inequalities;

   c   better IT systems and an information strategy ensuring improved care for
        patients;

   d   improving quality of care;

   e   workforce development;

   f   instigating a 'compact with the public'; and

   g   a changed financial regime.

12   http://www.wales.nhs.uk/documents/booklet-e.pdf
13   Welsh Government, *Together for Health: A five year vision for the NHS in Wales,* 2011.

1.43   The policy framework for the NHS in Wales is now being cast within the context of 'prudent healthcare', a concept that is based around the principles of:

   a   doing no harm;

   b   eliminating interventions with no clinical benefit;

   c   carrying out the minimal appropriate intervention;

   d   organising the workforce to maximise the use of skills across a range of healthcare professionals;

   e   promoting equity; and

   f   identifying the contribution that individuals can make to their own health and well being.

1.44   In October 2014 the Welsh Government launched *Making Prudent Healthcare Happen,* a web-based resource to explain the key concepts behind prudent healthcare[14].

1.45   A further key development has been the introduction of an NHS Wales Planning Framework[15] in November 2013, with updated guidance due to be published in the autumn of 2014. The framework seeks to strengthen the planning of NHS services via the production of medium-term (three-year) plans that integrate service outcomes, workforce and financial planning, with the aims of:

   a   addressing areas of population health need and improve outcomes;

   b   improving the quality of care; and

   c   ensuring best value from resources.

1.46   The Framework is supported by the establishment of a Welsh Government planning function with a defined remit of setting national planning requirements, constructively assessing plans produced by NHS bodies, and monitoring delivery of those plans in a way which is closely aligned to other elements of the Welsh Government's performance management regime. The application of the planning framework is discussed in more detail in Section 2 of this memorandum.

1.47   Numerous other policy documents support the overall vision set out in *Together for Health.* The most significant of these are:

   a   *Our Healthy Future* – published in 2009 this sets outs the Welsh Government's commitment and long-term vision to help people of Wales lead healthy lives with a particular emphasis on prevention and early detection, addressing inequalities and creating healthy sustainable communities.[16]

14   *Making Prudent Healthcare Happen* – http://www.prudenthealthcare.org.uk/
15   Welsh Government, *NHS Wales Planning Framework,* 2013.
16   Welsh Government, *Our Healthy Future: Technical Working Paper*, October 2009.

b   *Setting the Direction* – published in 2010, this document re-emphasised the need to rebalance services with stronger primary and community care services and less reliance on institutional forms of care.[17]

c   *Delivering Local Health Care: accelerating the pace of change* – launched in 2013, this plan built upon Setting the Direction by setting out a framework for action and accelerated change.[18]

d   *Working Differently-Working Together* – published in 2012, this sets approaches to develop the required staffing models that are required in integrated healthcare organisations.[19]

e   *Achieving Excellence – The Quality Delivery Plan for the NHS in Wales* – published in 2012, this sets out the Welsh Government's vision of a quality-driven NHS and the intentions of achieving excellence by 2016[20]. It identifies a key requirement for NHS bodies to publish an Annual Quality Statement to provide the public with a comprehensive source of information and assurance on the quality of their local services.

f   *Safe Care, Compassionate Care: A National Governance Framework to enable high quality care in NHS Wales* – published in January 2013, this document describes the roles, responsibilities, and systems that should be in place to seek and provide assurance on the quality and safety of health care services[21].

g   *Safe Care, Compassionate Care* – published in July 2013, this document outlines the Welsh Government's response to the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry, and sets out a vision for high-quality care in NHS Wales[22].

h   *A Framework for Assuring Service User Experience* – the framework[23], introduced in 2013, provides a national approach to measuring patient experience as required by Action 5 of the QDP.

i   *Putting Things Right* – Introduced in 2011, this is a set of regulations that aims to ensure proper handling of concerns about healthcare services.[24] The regulations aim to provide a single, integrated approach to managing complaints, incidents and claims, based on the principle of 'investigate once, investigate well'. These arrangements were subject to an independent review that reported in 2014[25].

17   Welsh Government, *Setting the Direction: Primary and Community Services Strategic Delivery Programme,* February 2010.
18   Welsh Government, *Delivering Local Health Care: Accelerating the pace of change,* 2013.
19   Welsh Government, *Working Differently – Working Together: A Workforce and Organisational Development Framework,* 2012.
20   Welsh Government, *Achieving Excellence – The Quality Delivery Plan for NHS Wales 2012-2016,* 2012.
21   Welsh Government, *Safe Care, Compassionate Care – A National Governance Framework to enable high quality care in NHS Wales,* January 2013.
22   Welsh Government, *Safe Care, Compassionate Care,* July 2013.
23   Welsh Government, *Framework for Assuring Service User Experience: Action 5 of 'Achieving Excellence, The Quality Delivery Plan',* April 2013.
24   Welsh Government, *Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011,* 2011.
25   Keith Evans, *A review of concerns (complaints) handling in NHS Wales: Using the gift of complaints,* June 2014

Funding flows

1.48 NHS Wales receives nearly all of its funding from the Welsh Government. This takes the following forms:

   a   revenue allocations to local health boards to secure hospital, community and primary care services for their resident populations;

   b   capital allocations to local health boards and NHS Trusts for operational and strategic capital developments; and

   c   targeted funding for health improvement and other Welsh Government initiatives.

1.49 Patients will generally receive treatment within the Health Board they are resident or registered in. The funding for this treatment is within the Health Board's revenue allocation, so there is no requirement for any flow of funding between organisations for this activity.

1.50 When patients are treated in an NHS organisation other than the Health Board in which they are resident or registered, there is need for a flow of funds between organisations. For patients treated by another NHS organisation in Wales, the Welsh Government does not dictate the basis on which the flow of funds is agreed between organisations. This is agreed locally between the organisations, although the Welsh Government does operate an arbitration process for resolving disputes between NHS Wales organisations in the limited situations this arises.

1.51 The Welsh Government does have an agreement with the other UK nations for the financial arrangements arising when Welsh patients receive treatment in other parts of the UK (and vice versa). Welsh residents treated in England are paid for using the Payment by Results tariff where this applies. Patients treated in Scotland and Northern Ireland, and in England where the tariff does not apply, are paid for at locally agreed rates.

Part 2

Key components of governance within the NHS in Wales

Accountability within the NHS in Wales

2.1 A number of arrangements exist to formally hold NHS bodies and those individuals working in them (and the wider NHS) to account for the delivery of services and agreed outcomes.

Arrangements to hold individuals to account

2.2 The Minister for Health and Social Services is held accountable for the performance of the NHS through the conduct of business within the National Assembly. Supported by officials, the Minister has the following roles:

   a   setting the policy and strategic framework for the NHS in Wales;

   b   agreeing in Cabinet, as part of collective discussion, the overall resources for the NHS in Wales;

   c   determining the strategic distribution of the overall NHS resources;

   d   setting the standards and performance framework for the NHS in Wales; and

   e   holding NHS leaders to account.

2.3 The Director General of the Welsh Government's Department of Health and Social Services (the Director General) is also the Chief Executive of the NHS in Wales. This person is appointed by the Welsh Government's Permanent Secretary and is both the Accounting Officer of the NHS in Wales and an Additional Accounting Officer within the Welsh Government.

2.4 The Director General is accountable for their personal performance to the Permanent Secretary. As Chief Executive, this individual is accountable to the Minister, and is responsible for providing the Minister with policy advice and exercising strategic leadership and management to the NHS.

2.5 The Minister appoints the Chair, Vice Chair and Independent Members to the Boards of NHS bodies. These individuals are held to account for their personal performance through annual accountability agreements linked to personal performance management arrangements. As part of this process the Minister will hold annual appraisal meetings with Chairs of NHS bodies.

2.6 The reshuffle of the Welsh Government Cabinet in early autumn 2014 resulted in the Deputy Minister for Health being given responsibilities for oversight of NHS delivery and performance in Wales. His role includes annual (mid-year) performance meetings with Chairs and Vice Chairs of NHS bodies that will cover all aspects of their organisations' performance, and the actions being taken to secure improvements.

2.7   Chief Executives of NHS bodies are formally held to account for their personal performance by their Boards, and specifically through the Chair. In relation to their role as Accountable Officers, they are accountable for financial and service delivery performance to the Chief Executive, NHS Wales. These arrangements are set out in documents called Accountable Officer Memoranda[26].

2.8   Accountable Officer Memoranda also set out the relationship between the Chief Executive of NHS Wales, as the Accounting Officer, and Accountable Officers within NHS bodies in Wales. The Chief Executive of NHS Wales may be summoned to the National Assembly's Public Accounts Committee (PAC) to answer questions relating to the accounts of NHS Wales or arising from wider examinations into the efficient, effective and economical use of NHS resources. Whilst the Chief Executive of NHS Wales will be regarded as the main respondent to any PAC enquiries about the wider stewardship of NHS funds, the PAC may also require Accountable Officers of NHS bodies to appear before them in their own right, depending on the matter under consideration. Accountable Officers of NHS bodies may also be called to appear before other subject Committees of the National Assembly for Wales.

2.9   Individuals in NHS bodies have responsibilities and accountabilities defined within clear schemes of delegation and their performance will be reviewed through the personal performance management that operates in the NHS. In addition, professional staff are also accountable to their professional bodies[27] in respect of the roles they perform.

Arrangements to hold NHS organisations to account

2.10   NHS organisations are held to account for their performance and the delivery of strategic and operational plans in a number of ways. External scrutiny comes in the form of statutory audit, inspection and review from:

a   The Auditor General for Wales

b   Healthcare Inspectorate Wales

c   Community Health Councils

d   The Health and Safety Executive

e   The Public Services Ombudsman

f   The Welsh Language, Older People's, and Children's Commissioners

2.11   There are well-defined arrangements for these external review organisations to share intelligence with each other and to co-ordinate programmes of review work.

2.12   Throughout the year, the Welsh Government will undertake activities to monitor and review the performance of NHS bodies in Wales. The Welsh Government's performance management arrangements are described in more detail in the following section.

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26   http://www.wales.nhs.uk/governance-emanual/accountability-in-nhs-wales
27   Includes bodies such as the General Medical Council and the Nursing and Midwifery Council

Health Professional Leadership

2.13 Within the Welsh Government, there are also number of key roles that collectively help guide and inform the work of the Welsh Government by providing professional and medical advice to the First Minister, the Minister for Health and Social Services and members of the cabinet, the Department for Health and Social Services, departments of the Welsh Government, and to external organisations. The Welsh Government has the following Chief Health Professionals[28]:

   a   Chief Medical Officer

   b   Chief Nursing Officer

   c   Chief Dental Officer

   d   Chief Pharmaceutical Officer

   e   Chief Optometric Advisor

   f   Chief Environmental Health Advisor

   g   Chief Scientific Advisor (Health)

   h   Therapy Advisor for Wales

Monitoring and reviewing performance and delivery

NHS Delivery Framework

2.14 The Welsh Government set outs its delivery priorities for NHS bodies within its NHS Delivery Framework[29]. The framework sets outs a number of 'Tier 1' targets and standards which are mapped to five 'quality domains':

   a   Need and prevention

   b   Service user experience and access

   c   Quality and safety

   d   Integration and partnerships

   e   Allocation and use of resources (staff and finance)

2.15 The Welsh Government makes use of a number of mechanisms to monitor delivery and to review performance against the Delivery Framework and other statutory and operational delivery requirements. These are summarised in Exhibit 2.

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28   http://wales.gov.uk/topics/health/cmo/?lang=en
29   Welsh Government, NHS Wales, *Delivery Framework 2013-14 and Future Plans*, 2013.
     http://wales.gov.uk/topics/health/publications/health/strategies/framework/?lang=en

Exhibit 2 – Mechanisms to monitor performance and hold NHS bodies to account

Welsh Government

Integrated Delivery Board

NHS Delivery Framework | **NHS Planning Framework**

Monitoring information

Chair-Minister Meetings | Quality and Delivery Meetings | Joint Executive Team Meetings

Chief Executive Meetings | Quality and Safety Assurance Group Meetings | National Quality and Safety Forum

Health boards and Trusts
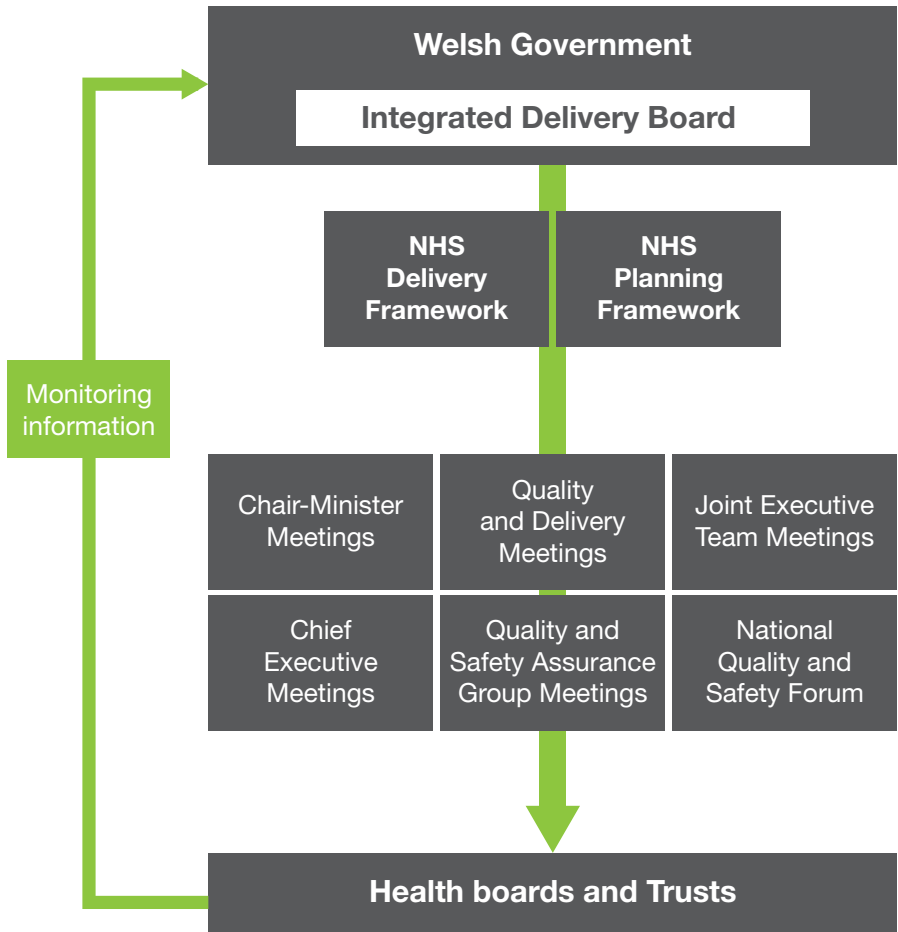
Source: Wales Audit Office research

2.16 Health boards and NHS trusts routinely submit data regarding finances, performance and quality to the Welsh Government. The Welsh Government uses this information to help scrutinise the performance in NHS Wales. The Welsh Government's Integrated Delivery Board (IDB) meets monthly to consider these data and is attended by Welsh Government policy leads, the Delivery Unit (see paragraph 2.22) and the NWIS.

2.17 Every other month, the Welsh Government and the Delivery Unit holds *Quality and Delivery Meetings* with health boards and trusts. These meetings are used to bring forward the issues discussed at IDB and to seek assurance that any concerns are being addressed. These meetings cover delivery and performance, finance, quality and safety, as well as workforce issues.

2.18 Quality and Delivery meetings take place within a framework of other regular meetings and forums that comprise the following:

a Biannual *Joint Executive Team (JET) meetings*, led by the Chief Executive of NHS Wales, in which the Welsh Government meets with the executive teams of individual health boards and NHS trusts to review and discuss organisational performance. Following each JET meeting, the Chief Executive of NHS Wales formally writes to the Chief Executive of each health board or NHS trust setting out the issues discussed, any concerns identified and specifying any improvements or actions required.

b Monthly *Chief Executive Meetings* between the Welsh Government and all trust/health board chief executives.

c Monthly *Quality and Safety Assurance Group Meetings*, chaired by the Deputy Chief Medical Officer with representatives from Welsh Government Policy and Performance divisions, as well as the Delivery Unit. The aim is to monitor the quality and safety of healthcare services through review of key indicators. Where concerns are raised, action can be taken through the IDB.

d Bi-monthly *Chairs and Minister Meetings* between all NHS trust and health board chairs and the Minister.

e A quarterly *National Quality and Safety Forum* which monitors implementation of the QDP and also oversees the implementation of *Delivering Safe Care, Compassionate Care.*

2.19 The above interactions are designed to complement internal performance monitoring and assurance processes within NHS bodies which are described in more detail later in this section. Where the interactions identify concerns about performance, health boards and NHS trusts are responsible for taking the immediate remedial action that is required.

2.20 The Welsh Government's NHS Delivery Framework sets out a number of escalation levels and arrangements that can come into play when there are concerns about an NHS body's performance. These are summarised in Exhibit 3.

Exhibit 3 – The escalation levels within the Welsh Government's NHS Delivery Framework

Escalation Level	Performance Trigger	Escalation Action	Monitoring	De-escalation
0	Local delivery of all targets or within trajectory.	None required – earned autonomy.		
1	Health boards/ trusts fail to achieve/maintain one deliverable.	Health boards/ trusts responsible for remedial action…plans brought forward to redress the position.	Welsh Government assures and monitors implementation of plans… support from other organisation if necessary.	Immediate removal of escalation action upon achievement of plan and return to improving Key Performance Indicators (KPIs).
2	Continued failure to achieve/maintain one or more key deliverables.	Welsh Government instigates Delivery Unit and/or other intervention.	Welsh Government monitors effectiveness of organisational response.	Sustained improvement of KPIs causes removal of escalation actions.
3	Continued failure and/or a failure to maintain an agreed improvement trajectory following intervention.	Issues raised with Chief Executive NHS Wales…to determine future requirements.	Regular reporting established between Chief Executive NHS Wales and health board/trust Chief Executive until improving trajectory established.	Maintenance of agreed improvement trajectories causes return to escalation level 2.
4	Continued failure to improve performance or failure to engage with the national process despite level 3 escalation.	Actions, to be determined by NHS Wales Chief Executive, may include the following: • Meeting with Chair, Vice Chair, Chief Executive, Board Secretary and/or relevant Executives of health board/trust • Introduction of 'special measure' arrangements • Review of executive effectiveness • Review of Board effectiveness • Removal of appropriate funding streams		

Source: Welsh Government

2.21   In March 2014, a separate but complementary set of escalation and intervention arrangements[30] were introduced in order to support regular information sharing and dialogue between the Welsh Government, the Auditor General for Wales and Healthcare Inspectorate Wales. These tri-partite arrangements consist of twice-yearly meetings to review the performance of NHS bodies, and to agree on how best to respond to any issues affecting NHS service delivery, quality and safety of care and/or organisational effectiveness. The arrangements permit more frequent meetings to be called when necessary. Where concerns are identified, there are three possible levels of intervention, each an escalation of the previous:

a   Enhanced monitoring – this includes more regular monitoring of performance and delivery, including more frequent meetings and the requirement for written updates and submission of evidence showing progress.

b   Targeted intervention – actions may include mentoring senior officials, appointing new senior officials on a temporary basis, and the carrying out of detailed reviews.

c   Special measures – these will be taken in exceptional circumstances and may include suspending or removing the powers and duties of senior officials. Also, the Minister may use emergency powers that direct one NHS body to take over the functions of another for a specified time.

2.22   It is important to note that Exhibit 3 describes the arrangements which currently form part of the Welsh Government's performance management arrangements for the NHS in Wales. These also now inform the discussions that are held as part of the wider tri-partite arrangements involving the Auditor General for Wales and Healthcare Inspectorate Wales, set out in paragraph 2.21. As the new escalation and intervention arrangements bed in it may be necessary to review the escalation arrangements set out in the Welsh Government's NHS Delivery Framework in order to achieve clear and consistent descriptions of escalation and intervention activity within NHS Wales.

Support to improve delivery

2.23   The Welsh Government has established a Delivery Unit to support organisations that are having difficulties with certain aspects of service delivery. The Delivery Unit was formed in April 2013 from predecessor organisations called the Delivery and Support Unit (DSU), National Leadership and Innovation Agency for Healthcare (NLIAH), the National Patient Safety Agency (NPSA) and the Clinical Governance Support and Development Unit (CGSDU). The Unit's activities are a mixture of mandatory interventions (via the Delivery Framework escalation process), and work in response to requests for support from NHS bodies.

30   Welsh Government, *NHS Wales Escalation and Intervention Arrangements,* March 2014.

The NHS Planning Framework

2.24 As indicated in Part 1 of this memorandum, an NHS Planning Framework was introduced in November 2013, with a revised version due for publication in Autumn 2014. The Framework confirms the importance of NHS bodies establishing balanced medium-term plans and sets out the evidence that the Welsh Government expects to underpin plans.

2.25 Scrutiny and assurance is a critical component of the system outlined in the Planning Framework. NHS bodies are expected to subject their draft plans to appropriate internal scrutiny before they are submitted to the Welsh Government for further rigorous testing and assessment.

2.26 Based on its assessment of medium-term plans, the Welsh Government decides whether or not to allow health organisations to have three-year flexibilities in their budgeting (as described in the NHS Finance (Wales) Act 2014). Organisations granted the three-year flexibility are not obliged to break even every year, but must do so after three years. This flexibility is designed to give NHS organisations more scope to plan for the long term. If a health board or NHS trust is not able to produce a suitably robust medium-term plan, they will continue to operate on a one-year planning cycle until such time that they are able to produce a three-year plan of sufficient quality. Flexibilities which have been granted can be removed if there are significant concerns about an NHS organisation's ability to meet its delivery targets and agreed trajectories.

2.27 One year on from the launch of the planning framework, four NHS organisations in Wales had entered the three-year medium-term planning arrangements, with the remaining organisations agreeing one-year plans and the steps that were necessary to develop medium-term plans of the required quality.

2.28 Updated guidance[31] published in the latter part of 2014 set out what is required from NHS bodies as the new planning system moved into its second year, including further detail on the plan approval processes, and the actions that are to be taken to strengthen the planning discipline and profession across NHS Wales.

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31   http://gov.wales/docs/dhss/publications/141031frameworken.pdf

Financial stewardship and control

2.29 Health bodies are also subject to a range of frameworks and requirements in relation to financial control and stewardship. Health boards have statutory obligations to meet their revenue resource limit over a three-year rolling period (ie, not exceed the amount they are allowed to spend) and have a three-year plan in place. NHS Trusts must break even in-year and whilst they are expected to have a three-year plan in place, this is not a statutory duty. The bullet points below provide further detail on the main frameworks and requirements regarding financial control and stewardship:

a Welsh Health Circulars and Ministerial Letters (as explained in paragraph 1.32) provide requirements over and above those set out in statute.

b Managing Public Money (MPM)[32] sets out the main principles for dealing with resources in public sector bodies. The Welsh Government is currently updating the Managing Welsh Public Money (MWPM) but bodies are recommended to use the current MPM version until the updated MWPM is issued.

c The Financial Reporting Manual (FReM)[33] is the technical accounting guide that sets out how public bodies should prepare their financial statements.

d The Manual for Accounts (MFA)[34] is a manual that sets out the accounting policies to be followed by NHS bodies and provides principles-based guidance on how they should prepare and complete their annual accounts. Chapter 3 details the annual reporting requirements for NHS bodies to publish their accounts and an Annual Report, Annual Governance Statement and Annual Quality Statement.

Governance frameworks within NHS bodies

2.30 Each NHS body in Wales is responsible for maintaining appropriate governance arrangements to ensure that it is operating effectively and delivering safe, high-quality care to patients. Organisations and services should operate within a robust framework for decision making and accountability designed to achieve successful delivery of their strategic objectives, in a way which:

a upholds organisational values and standards of behaviour;

b complies with regulatory requirements, standards, directions and instructions;

c secures the efficient, effective and economic use of resources;

d safeguards and protects assets, including its people; and

e ensures good governance when working in partnership with others.

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32 HM Treasury, *Managing public money,* July 2013
33 HM Treasury, *Government financial reporting manual 2014 to 2015*
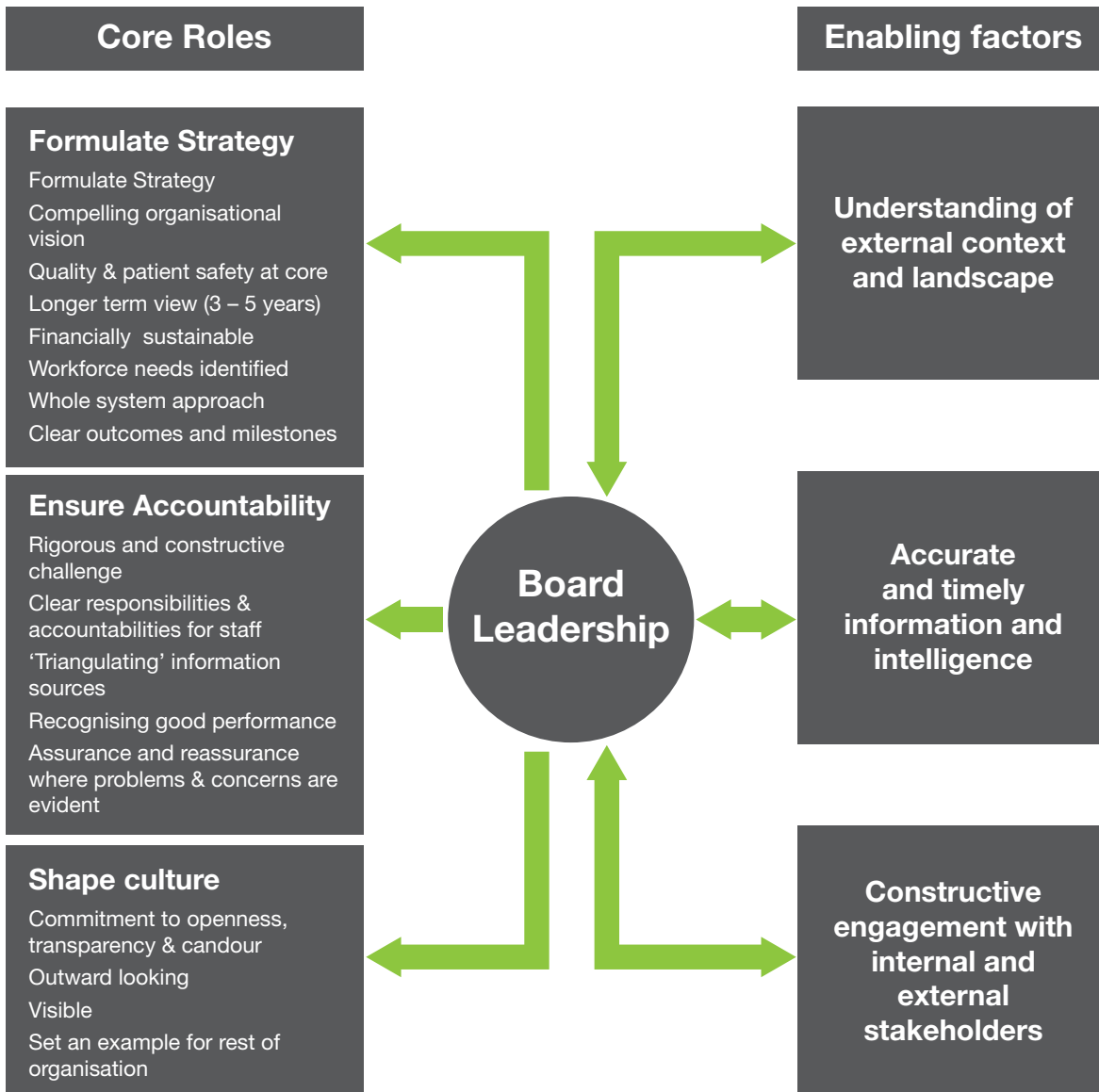34 Welsh Government, *IFRS Manual for Accounts 2013-14*

The role of Boards

2.31 The Boards of NHS organisations need to govern their organisation effectively and in doing so build public and stakeholder confidence that their health and healthcare are in safe hands.

2.32 The NHS Leadership Academy[35] has helpfully set out the key areas in which Boards need to demonstrate leadership within their organisations. These are summarised in Exhibit 4 as the core roles which Boards must undertake and the enabling factors that help them exercise these roles.

2.33 NHS Boards in Wales are comprised of the following members:

a   *The Chair* – whose role is to manage and develop the Board.

b   *The Chief Executive* – whose role is to be the Accountable Officer, and be the operational leader of the organisation.

c   *Executive Directors* – who have a dual role as Board members, and operational executive leads for their part of the organisation, with Medical Directors, Nurse Directors and Directors of Therapies having specific roles that provide a clinical voice at the Board.

d   *Independent Members* – whose role is to provide independent thinking, objectivity, governance and expertise.

e   *Associate Members* – who attend Board meetings on an ex-officio basis but do not have voting rights.

2.34 All Board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also have a shared responsibility for ensuring that the Board operates as effectively as possible. Chapter 4 of the Good Governance Guide for NHS Wales Boards[36] provides a helpful further analysis of the different roles played by Board members in delivering the NHS body's core roles.

35 NHS Leadership Academy, *The Healthy NHS Board 2013: Principles of Good Governance,* 2013.
    http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf
36 http://leadershiplearning.academiwales.org.uk/uploads/attachments/nUpPd63yp.pdf

Exhibit 4 – Board Leadership

Core Roles

Enabling factors

Formulate Strategy

Formulate Strategy

Compelling organisational vision

Quality & patient safety at core

Longer term view (3 – 5 years)

Financially sustainable

Workforce needs identified

Whole system approach

Clear outcomes and milestones

Understanding of external context and landscape

Ensure Accountability

Rigorous and constructive challenge

Clear responsibilities & accountabilities for staff

'Triangulating' information sources

Recognising good performance

Assurance and reassurance where problems & concerns are evident

Board Leadership

Accurate and timely information and intelligence

Shape culture

Commitment to openness, transparency & candour

Outward looking

Visible

Set an example for rest of organisation

Constructive engagement with internal and external stakeholders

Source: Adapted from NHS Leadership Academy (2013)

Committees of the Board

2.35 The Board is required to appoint committees 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 can establish a committee structure that best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, however, the Board must establish committees which cover the following key aspects of board business:

   a   Quality and Safety

   b   Audit

   c   Information Governance

   d   Charitable Funds

   e   Remuneration and Terms of Service

   f   Mental Health Act requirements (where applicable)

2.36 With Board approval, other committees and sub-committees may be established to assist in the conduct of NHS organisations' business. In addition, Standing Orders require Boards to form a number of advisory groups that allow Boards to take account of the interests of stakeholders in communities they serve, its officers and health professionals, and to support effective partnership working with other NHS bodies and local authorities.

2.37 All Board committees normally have an Independent Member as chair. Audit Committee members are all non-executive officers, with executives in attendance as appropriate. At least one member of the Audit Committee must have a financial background. It is important that checks and balances are maintained in relation to committee membership to avoid potential conflicts of interest, for example, by ensuring that the Board Chair is not a member of the Audit Committee.

2.38 In developing their governance arrangements and committee structures, Boards of NHS bodies need to ensure that they do not inadvertently create unconnected 'silos' or overlapping functions. They therefore need to ensure that the principles of integrated governance are properly considered and that their assurance frameworks allow the Board to receive holistic information that links together corporate, clinical, financial and information governance.

Sources of assurance

2.39   NHS Boards need to gain assurance on the extent to which their organisations are operating effectively and delivering their strategic vision and objectives. In particular, assurances need to cover:

   a   compliance with relevant legislation, regulations, standards and other directions and requirements set by the Welsh Government;

   b   the reliability, integrity, and security of the information collected and used by the organisation; and

   c   the provision of high-quality and safe healthcare for its citizens, and the efficient, effective and economical use of resources.

2.40   These assurances need to extend beyond an organisation's own arrangements in order to cover partnership working and the provision of shared services as appropriate.

2.41   Boards can receive assurances from a wide range of sources, both internal and external to the organisation. These are summarised in Exhibit 5.

Exhibit 5 – Sources of assurance

Internal assurances	External assurances
• Internal Audit • Self assessment against the Standards for Health Services in Wales • Clinical Audit • Local Counter Fraud work • Welsh Risk Pool • Reports from committees and advisory groups • Performance reports • Incident reporting • Complaints monitoring • Reporting against milestones in annual and medium-term plans • Staff surveys	• External audit reports and opinions, including annual structured assessments of governance arrangements • Healthcare Inspectorate Wales reports, investigations and spot checks • Community Health Council • Royal Colleges • Deanery visits • Public Service Ombudsman • Older People's, Children's and Welsh Language Commissioners • External advisors and peer reviewers • External benchmarking exercises

Source: Wales Audit Office and Good Governance Guide for NHS Wales Boards

2.42 Within the sources of internal assurance shown in Exhibit 5, it is worth highlighting a number of arrangements that form a fundamental part of NHS bodies' governance arrangements. These are explained further below:

a   *Internal audit* – this provides a key source of independent internal assurance to Boards and Chief Executives (as Accountable Officers). Internal audit forms a part of the NWSSP described in paragraphs 1.12 – 1.14. There is an annual programme of internal audit work at each NHS body in Wales that results in a series of individual audit reports, and allows the Head of Internal Audit to produce an overall annual opinion on the organisation's risk management, control and governance. The work of internal audit is overseen by the Board's Audit Committee.

b   *Clinical Audit* – this is the systematic analysis of the processes and procedures used in the delivery of healthcare, against recognised evidence-based standards and practices. Clinical audit will typically be undertaken as part of clinical professionals' education and development. However, its main purpose should be to improve the quality of patient care. As such, Clinical Audit findings should be reported through the organisation's structures to the Board as part of the NHS body's arrangements for ensuring the quality and safety of care.

c   *Welsh Risk Pool* – this is a mutual organisation which provides indemnity to all Health Boards and NHS trusts in Wales and forms part of the NWSSP. The Risk Pool provides support to NHS trusts and local health boards in the development of robust risk management systems, informed by specific review work in the areas of A&E, operating theatres and maternity services.

d   *Local Counter Fraud work* – Wales has a Counter Fraud Services (CFS) team consisting of experienced investigators who deal with large-scale, complex frauds and all corruption issues in NHS Wales. Directions also stipulate that NHS bodies in Wales must nominate a suitable person to act as their Local Counter Fraud Specialist (LCFS). The CFS Wales Team provides support and guidance to the network of LCFSs, who usually investigate smaller value fraud cases within their own health bodies. The LCFSs work with CFS Wales to help develop a robust counter fraud culture and secure criminal, civil and disciplinary sanctions when appropriate.

2.43 External assurance can be mandated or commissioned. There are key distinctions between the two and it is important to note that independent statutory external review work, such as that undertaken by the Auditor General and Healthcare Inspectorate Wales, is designed to provide assurance to citizens and other stakeholders, and not to the Board. That said, external assurance activities typically provide important insight, information and recommendations for improvement, and Boards need to have well-defined arrangements in place to take effective action in response to external review findings.

Risk management and Board Assurance Frameworks

2.44 NHS bodies need to have well-developed processes for both identifying and managing the risks associated with the planning and delivery of healthcare services. Risk consideration should underpin the development of strategic and operational plans, decision-making processes and the allocation of resources. Risk-management processes then need to be embedded into corporate and operational working arrangements.

2.45 All health boards and NHS trusts are expected to maintain a corporate risk register detailing the principal risks for the organisation and its achievement of strategic objectives. Each Board committee takes the lead for the risks associated with their portfolio, whilst the Board maintains a strategic overview. Sitting below the corporate risk register, there needs to be an appropriate suite of operational risk registers covering the main areas of service delivery. More broadly, the approach to risk management requires the Board to be clear about its risk appetite, or tolerance to risk, and the controls needed to mitigate those risks.

2.46 Boards need to underpin their approach to risk management by having a clearly defined Board Assurance Framework. The formats of Board Assurance Frameworks can vary but typically they need to identify and map:

    a   the organisation's strategic aims and objectives;

    b   the risks to achieving each objective (including likelihood, impact and severity);

    c   the systems and controls in place to mitigate risks;

    d   the assurances needed by the Board;

    e   gaps in controls and assurances; and

    f   actions aimed at addressing these gaps.

The role of the Board Secretary

2.47 The Board Secretary plays a crucial role within NHS bodies in Wales. Independent of the Board, the Board Secretary is a key source of advice and support to the Chair and other Board members. Acting on behalf of the Chair and Chief Executive, the Board Secretary is expected to lead the design and development of a governance and assurance framework for the organisation.

2.48 The Board Secretary reports on a day-to-day basis to the Chief Executive but is accountable for the conduct of their role to the Chair. As advisor to the Board, the Board Secretary's role does not affect the specific responsibilities of Board members for governing the organisation.

Transparent public reporting

2.49   There is a requirement for health boards and trusts to provide assurance to the public on the organisation's performance and the quality and safety of the services provided. Chapter 3 of the *Manual for Accounts* (referred to in paragraph 2.28) sets out the requirement for NHS bodies to publish an Annual Report and accounts. The Annual Report should be supported by the following separate statements:

   a   Annual financial statements – a full set of audited accounts to include the primary financial statements and notes, and the audit opinion and report.

   b   Annual Governance Statement (AGS) – setting out Board membership and responsibilities, the schedule of committee meetings, details of internal governance and risk frameworks, sources of internal and external assurance and a self-assessment against standard 1 of *Doing Well, Doing Better: Standards for Health Services in Wales* – Governance and Accountability.

   c   Annual Quality Statement (AQS) – providing the public with information and assurance about the quality and safety of their services.

2.50   In addition to the above, public information about the performance of health services in Wales can be found on *My Local Health Service*[37], an online facility that provides a comparative picture of performance of GP practices, hospitals and health boards across a range of measures. The intention is to continue to evolve the information presented on this website as part of a 'journey of honesty and increasing openness'.

37   *My Local Health Service*: http://mylocalhealthservice.wales.gov.uk/#/en

Part 3

The way that governance arrangements in NHS bodies are working in practice

3.1 NHS bodies in Wales are operating the governance arrangements described in Part 2 in a particularly demanding environment. This environment is characterised by the need to deliver high-quality, safe services within a system that is experiencing hitherto unseen financial constraints and increasing demand. Exhibit 6 highlights the range of challenges that NHS Boards in Wales are currently grappling with.

Exhibit 6 – Challenges facing NHS Boards
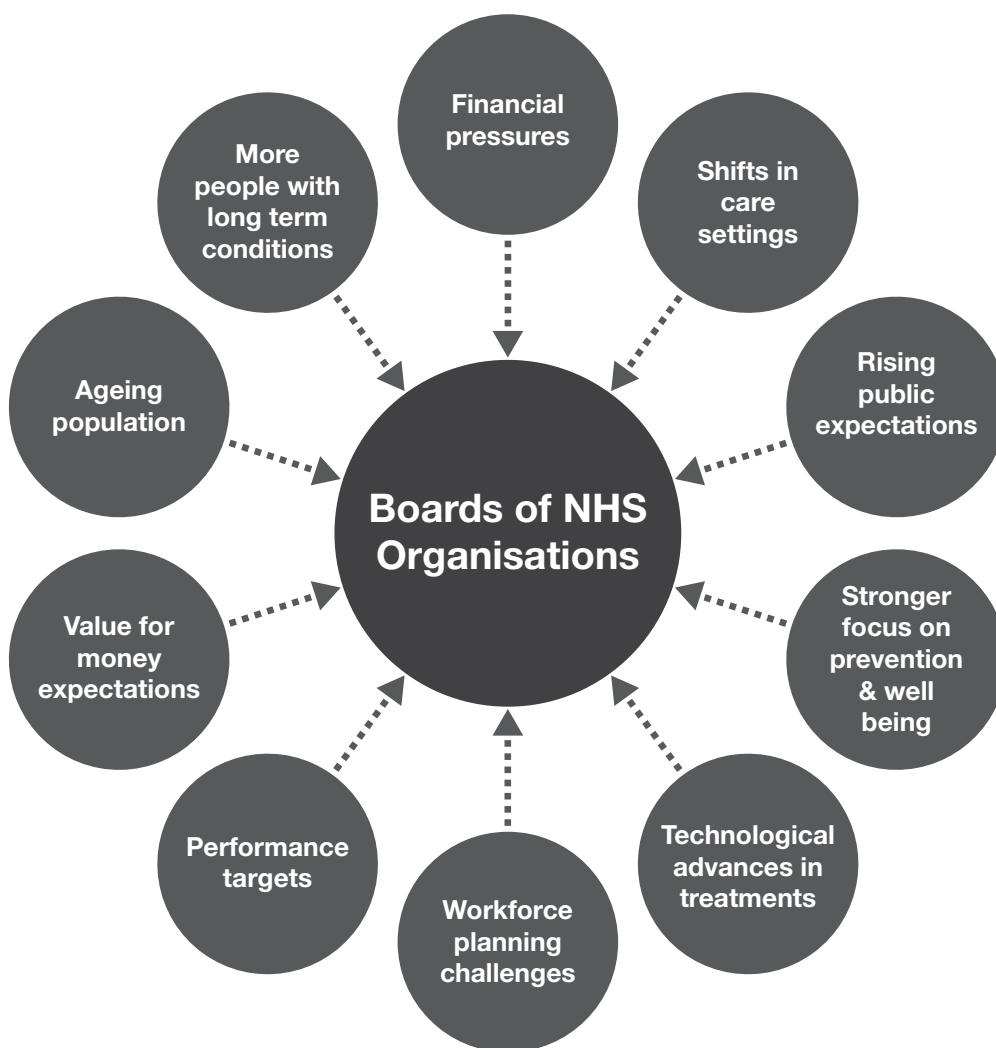
Source: Adapted from NHS Leadership Academy 2013

3.2   In this part of the memorandum we draw upon our local audit work at NHS bodies to give a high-level overview of how we see the governance arrangements working in practice at health boards and trusts.

Overall perspectives

3.3   There is no doubt that NHS bodies in Wales are working hard to ensure that they have governance arrangements in place which are fit for purpose, and which provide assurance to themselves, the public and other stakeholders on the quality, safety and value for money of the services they provide.

3.4   The creation of large integrated health boards in 2009 brought with it a number of specific governance challenges associated with the size and complexity of these organisations. Since then, our local audit work has seen the governance arrangements of NHS bodies continue to evolve to the extent that, in the main, the necessary structures and processes are in place.

3.5   However, the key is the extent to which these governance arrangements operate as intended. Whilst there is no pan-NHS Wales evidence of the very serious care failings that were evident in Mid Staffordshire NHS Trust, there have been worrying and well-publicised problems with governance and clinical care in individual organisations such as the Betsi Cadwaladr and Abertawe Bro Morgannwg University Health Boards. In both these organisations, work is still underway in response to the failings that have been identified.

3.6   This shows that there can be no complacency on the parts of Boards of NHS bodies in Wales, or the Welsh Government, in ensuring that governance arrangements are sufficiently well developed to provide the necessary assurances on the quality and safety of care and financial stewardship of public money.

3.7   Our work has shown that whilst most NHS bodies have the necessary governance structures and processes in place, certain aspects of these need to evolve further to ensure that Boards are properly equipped to lead their organisations through the challenges that they face.

3.8   In the sections that follow, we present high-level findings on:

a   how effectively Boards and committees operate;

b   the overall shape of governance and assurance frameworks within NHS bodies;

c   the information sources that are used to provide assurances to Boards and committees;

d   the extent to which organisational learning is evident; and

e   the robustness of self-declarations by NHS bodies.

3.9   The findings are drawn from our annual assessments of the corporate governance arrangements in NHS bodies which have been presented in Annual Audit Reports to NHS bodies. These assessments, are by their nature high level, although they have permitted auditors to highlight which aspects of NHS bodies' governance arrangements need to be strengthened.

Operation of the Board and its committees

Conduct of meetings

3.10   In their observations at Board and committee meetings across Wales, auditors have typically found the meetings to be well chaired with increasing evidence of appropriate challenge by Independent Members. On occasions, however, auditors have observed a need for a more robust approach to be adopted in holding officers to account.

3.11   There is evidence that NHS bodies are adopting an increasingly transparent approach to the conduct of their business. The Boards of NHS bodies will meet in public, and whilst committee meetings in most NHS bodies are in private, the minutes of these meetings are subsequently included in public Board papers.

3.12   However, there is notable variation between NHS bodies in the extent to which core business information is placed in the public domain. Whilst most NHS bodies will only make Board papers public, others such as Cardiff and the Vale University Health Board make their committee papers public.

3.13   As would be expected, the vast majority of Boards and committees are quorate when they meet, although auditors have observed occasional meetings where the absence of Independent Members has hindered the effective conduct of the meeting. This raises a wider issue about whether the time some Independent Members have is sufficient for what can be a challenging and time-consuming role.

3.14   Board development sessions are used to improve Board effectiveness, review arrangements and support development of the Board and its members. However, the regularity of independent member induction training and briefing on particular service issues may not adequately support newcomers in becoming confident in their role.

3.15   Self-assessment is an important tool used by Boards and committees to review their effectiveness. While the practice of self-assessment is widely adopted, the approach is not always carried out on a regular basis or universally applied by all Boards and committees.

Agenda management and quality of papers

3.16   The sheer volume of the business of some Boards and committees can present significant challenges for NHS bodies in terms of agenda management. A large proportion of information presented to Boards and committees is marked for noting and there is scope to more explicitly signpost critical information in Board papers so that time is used most effectively. This could be achieved by ensuring the purpose of papers presented at committee and Board is more clearly identified for example, for 'information', 'scrutiny or discussion', 'approval' or 'decision'.

3.17   This is particularly important given that sets of Board and committee papers include detailed and often quite technical information and typically run in excess of a hundred pages. Making this information more 'digestible' is an on-going challenge and shorter, more structured highlight reports could help better focus the business of meetings and ensure they run to time.

3.18   Internal 'rules' for the completeness and format of papers have been developed with many Boards and committees using a template approach. However, the quality of papers can still be variable with some papers not sufficiently clear about the key risks and assurances provided.

3.19   Whilst the above issues are largely administrative in nature, they are nonetheless critical to the effective running of the organisation. Lengthy and undifferentiated agendas run the risk that important issues scheduled for later on in meetings get insufficient attention, or are deferred. Whilst this is not a regular occurrence it does occasionally occur.

Outcomes from meetings

3.20   Boards and committees need to clearly demonstrate in the formal records that they have appropriately responded to the information presented. This should ensure that decisions are clearly and formally recorded, required actions are documented in action plans and that significant issues and risks are identified and escalated when required.

3.21   The minutes of meetings form the formal record of Board and committee discussions and decisions, with action logs used to track the agreed actions. Audit Committees have also established processes for tracking responses to internal and external audit recommendations, although tracking arrangements for other Committees, such as Quality and Safety, are often less consistent or systematic.

3.22   Boards receive the minutes from their committees and these are included in the Board papers. Committee Chairs report to each Board meeting on the work of their committee, identifying and escalating relevant matters. Some NHS bodies have also introduced summary exception reporting to more explicitly highlight assurances and risks within the committee work programmes, although this practice is not commonplace.

3.23   Our work has also identified that there is scope for greater clarity around the outcome of discussions during meetings, and that Boards could do more to follow up on strategic plans and strategies to assess whether previously agreed actions have been achieved.

Governance and assurance frameworks

Committee structures

3.24   Health Boards in Wales have kept their committee structures under review as they look to establish the most effective governance arrangements for their organisation. Whilst all organisations initially based their committee structures upon the model standing orders as described in paragraph 2.34, several Health Boards have since reviewed and amended their Committee structures to ensure better information exchange between the different committees and a more integrated flow of assurances to the Board. Typically this has involved the introduction of additional committees to support integrated governance and to more explicitly review performance and delivery. The current configuration of key committees within NHS bodies in Wales is summarised in Appendix 2.

3.25   The key challenge for NHS Boards is to adopt a committee structure in which the various sub-committees and groups work together effectively to constitute a robust overall framework for assurance and support. This is fundamental to ensure that there is a clear line of sight between operational service delivery and the Board.

3.26   In the main the introduction of amended committee structures within Health Boards has helped strengthen governance arrangements, although that is not universally the case. Even where structures have been amended, there can still be challenges around ensuring there is an effective flow of information between committees, and ultimately to the Board. This is, however, something that NHS bodies are aware of and it remains an area of on-going review.

3.27   There are particular challenges for Quality and Safety Committees. Unlike the Audit Committee which has a well-embedded programme of assurances provided by a range of expert assurance providers, the assurances provided into Quality and Safety Committees are more reliant on assurance flows from a range of sub-Committees and management groups. This presents additional challenges around ensuring there is an effective flow of information to the committee. Given that so much of an NHS organisation's business can be classed under the theme of quality and safety, there is also an on-going challenge in keeping the agenda for this committee manageable whilst ensuring that important quality and safety issues are adequately considered.

Executive and operational management structures

3.28 All NHS bodies have established a clear executive management structure with accountabilities allocated across a team of Executive Directors. There are, however, some variations in the organisational structures that have been adopted by NHS bodies and in particular Health Boards. Organisational structures that include defined communities or localities are evident in a number of health boards and most offer the scope for coterminosity with local authorities, particularly for the provision of primary care and community services. In others there have been more explicit attempts to base the organisational structure around defined clinical areas or pathways.

3.29 A key challenge, particularly for large Health Boards is to ensure that their organisational structures are predicated on clear lines of accountability for operational management and delivery. In the main, NHS bodies in Wales have achieved this and have avoided some of the problems that have been described recently at Betsi Cadwaladr University Health Board[38] where particular challenges were evident in relation to:

a   lines of accountability and performance management arrangements at operational levels;

b   ensuring adequate management at the hospital site level within an organisational structure based around clinical programmes; and

c   the flow of assurances from ward to board.

3.30 Organisational structures within the larger health boards are described more fully in Appendix 3.

Risk management and Board Assurance Frameworks

3.31 Boards of NHS bodies in Wales need to take a view on a diverse range of risks. Audit work has indicated that NHS bodies' approaches to risk management have continued to evolve such that risk registers are more explicitly making the connections between strategic objectives, corporate risks and various sources of assurance. However, these arrangements are at different levels of maturity across Wales and for some NHS bodies more work is needed in this area.

3.32 The understanding of what constitutes a framework of board assurance has matured over recent years and NHS bodies have continued to refine their assurance systems, accounting for Welsh Government guidance and the requirements for quality assurance as set out in *Safe Care, Compassionate Care, a national governance framework*[39].

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38   Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office: *An Overview of Governance Arrangements in Betsi Cadwaladr University Health Board,* June 2013

39   Welsh Government, *Safe Care, Compassionate Care: A National Governance Framework to enable high quality care in NHS Wales,* January 2013

3.33 However, the documenting of local framework arrangements does vary in depth, ranging from a statement of principles to a more explicit description of controls and assurance mechanisms. Some Health Boards such as Aneurin Bevan University Health Board have pictorially described their overall governance and assurance framework (Exhibit 7).

Exhibit 7 – Aneurin Bevan University Health Board Governance and Assurance Framework
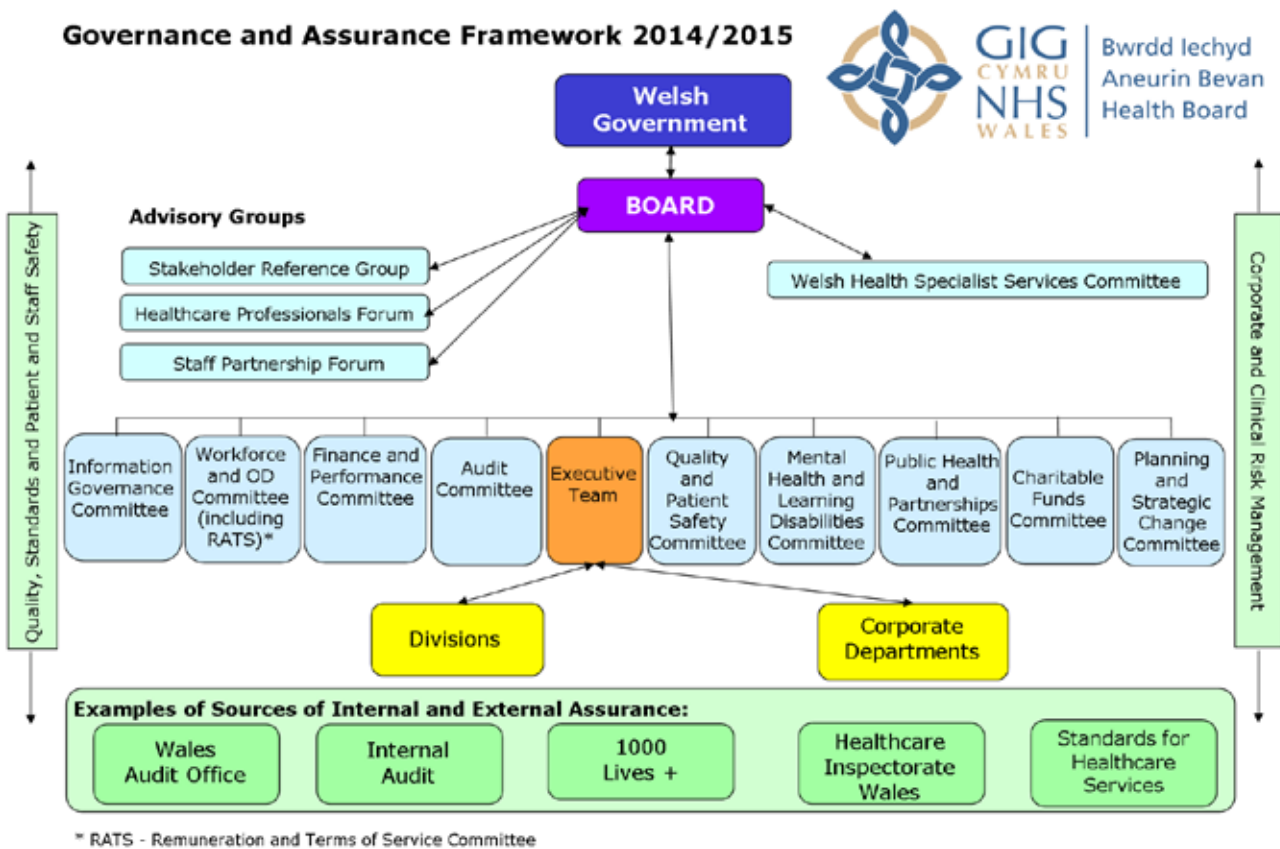
Source: Aneurin Bevan University Health Board http://www.wales.nhs.uk/sitesplus/866/page/52736

The role of Board Secretaries

3.34   In all Health Boards and NHS trusts, Board Secretaries are employed as the principal governance advisers to Boards.[40] The joint review at Betsi Cadwaladr University Health Board identified problems that resulted from the Board Secretary having too broad a span of responsibility. Since then a number of NHS bodies have re-examined the role and capacity of their Board Secretary function. Despite this, however, Board Secretaries in many NHS bodies still have senior management responsibilities for other corporate functions such as communications and media.

3.35   This is an area that NHS bodies will need to keep under review. Beyond ensuring that the Board Secretary has a manageable portfolio of responsibilities, Boards will need to ensure that the Board Secretary's fundamental role in ensuring good standards of governance is not compromised by them having significant operational delivery accountabilities.

3.36   One of the elements of the Board Secretary role is to help develop arrangements for Boards to obtain assurance that they are meeting their legislative requirements. However, this has proved to be challenging and most NHS bodies have struggled to develop a clear process for ensuring full compliance with all legislative and regulatory requirements, most notably because there does not appear to be a single, comprehensive inventory of such requirements. As a rule NHS bodies have focussed primarily on licensing and high-risk legislation such as Health and Safety, mental health and equalities.

Information used to provide assurance

3.37   In recent years, auditors have noted ongoing improvements in the quality and range of information provided to Boards and their committees to support assurance processes, scrutiny and decision making. Performance, financial and quality reports are routinely provided to Boards (or their relevant committee) in the forms of summary reports and more detailed dashboards. However, if Boards are to adequately assess organisational performance and the quality and safety of services, they need to examine additional sources of information and intelligence as part of their assurance framework. These points are discussed more fully in the following paragraphs.

Reporting of operational performance and quality

3.38   There have been notable improvements in the content and format of reports to Boards on how the organisation is performing against key service and performance targets. This has helped ensure Board members are well briefed on key aspects of performance of the organisation.

3.39   The monitoring of performance trends over time is well embedded and there is evidence of increasing use of benchmarking comparisons. However, Boards often do not receive detailed comparisons on how their own organisation's performance compares to others in Wales and elsewhere.

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40   In Powys this role is performed by a corporate governance manager.

3.40 In addition to enhancing benchmarking comparisons, auditors have noted scope for NHS bodies to improve performance reporting in respect of:

a   receiving a suite of performance metrics that better covers the totality of the organisation's responsibilities; in the case of health boards this relates to going beyond 'Tier 1' measures to present a wider suite of information on primary, community and specialist care, as well as partnership-based services;

b   more clearly identifying where responsibilities sit for securing improvements when performance is below the required or expected level; and

c   having a more explicit approach to setting milestones and targets for local priorities and objectives.

3.41 Quality and safety reporting has been evolving rapidly over the last couple of years, stimulated in large part by the events in Mid Staffordshire and rising public and political pressure to report more openly and transparently on such matters.

3.42 Whilst this means that the information Boards get for assurances on quality and safety matters is getting better, it needs to improve further. Boards now get a reasonable suite of information on important areas such as mortality, healthcare-associated infection, incidents and concerns and complaints. However, less information is available on patient experiences and outcomes, and how organisations benchmark to one another.

3.43 There is also scope for Boards to be more specific in defining standards and aims in relation to quality of care. This in turn would help focus the work plans of Quality and Safety Committees and provide a framework for reporting in the AQS.

3.44 Importantly, Boards need to continue to evolve their approach to quality and safety monitoring to ensure that they receive early warnings of when things may be going wrong, so that proactive action can be taken. Current arrangements for quality monitoring contain the risk that responses, even if they are swift and meaningful, will still be reactive. The use of quality triggers is one way in which monitoring can become more predictive, but this work is still in its early stages in Wales.

Monitoring patient experience

3.45 Auditors have pointed to the need for further developments in relation to the use of patient experiences as part of the Board's assurance processes, Whilst NHS bodies are continuing to improve approaches for capturing, and analysing patient feedback information, there is variation in the level of patient feedback activity and in the approaches used for capturing feedback within and across NHS bodies.

3.46 The all-Wales framework for assuring service user experience, introduced in 2013 now provides a common methodology, although full implementation has yet to be achieved in all service areas in NHS bodies.

3.47   There is, however, a positive culture to build upon:

   a   most Boards recognise the value of listening to patients and are demonstrating openness to learning lessons to improve quality, safety and patient experience;

   b   'Patient Stories' and reports on patient feedback and the activity being undertaken to capture patient experience are now being routinely reported at Boards; and

   c   Independent Members are giving more time to understand the patient experience through visits, 'walkabouts', and engagement with stakeholders.

Financial information

3.48   Typically, Boards receive good financial information on capital and revenue expenditure, details of savings scheme performance, emerging financial risks and financial forecasts. Financial information is generally based on the monitoring returns that NHS bodies provide to the Welsh Government each month. As a result, the information is broadly consistent across NHS bodies.

3.49   NHS bodies are getting better at understanding and reporting the implications that decisions related to financial savings will have on the delivery of services. However, the financial information underpinning plans and strategies presented to Board for decision making or approval is not always as robust. This makes it difficult for Board members to know if a plan or programme is affordable and whether there will be a financial or health return on the investment made.

3.50   Our work on NHS Finances[41] has identified that many of the assumptions included in organisations' medium-term plans appear optimistic in terms of the level of financial savings and service improvements required to achieve their three-year plan. Therefore it will be important for Boards to:

   a   consider and clarify what may happen if financial assumptions prove optimistic;

   b   develop clear contingency plans; and

   c   produce robust savings plans over the medium and long term that are clearly linked to plans for service change.

Triangulating information from different sources

3.51   It is important for Board and committee members to be able to form opinions and judgements based on an assimilation of information from multiple information sources. Such 'triangulation' helps focus challenge and scrutiny and ultimately supports good risk management.

41   Auditor General for Wales, *NHS Wales: Overview of financial and service performance 2013-2014*, October 2014

3.52   There is evidence of deliberate efforts to triangulate performance information with other sources of assurance, such as Board member 'walkabouts', and patient experiences and complaints. However, there is still a need for more integrated information on finances, activity, quality and resources to support more effective planning decisions and provide a more rounded view of organisational performance.

Response to concerns and organisational learning

3.53   Boards of NHS bodies are demonstrating an increasing commitment to developing a positive listening and learning culture but responding to complaints in a timely manner is problematic, and a more systematic, co-ordinated approach is needed to ensure effective organisational learning. The following paragraphs provide further analysis of audit findings in these areas.

Complaints and concerns from patients

3.54   Boards of NHS bodies are generally trying to set a positive tone for complaint management and response, but better compliance with the requirements of *Putting Things Right* and more effective responses to complaints are needed. Audit work has noted that:

a   complaints are not always responded to in a timely way and some organisations still have a large complaints backlog;

b   investigations into complaints can be compromised by a lack of clinical input and wider capacity issues within compliant investigation teams;.

c   delays in securing appropriate and timely responses from services and clinical divisions can impact on the ability of staff handling complaints to respond quickly;

d   the tone and style of response to complainants is sometimes inappropriate and unhelpful; and

e   there is limited evidence of senior managers being held to account for not responding promptly and appropriately.

3.55   Similar issues to those listed above were raised in a recent independent review of NHS complaint handling.[42] Moreover, the Public Services Ombudsman has separately concluded that there are failings in how effectively complaints are addressed by NHS bodies[43], following the increasing number of referrals to his Office.

42   Keith Evans, *A review of concerns (complaints) handling in NHS Wales: Using the gift of complaints*, June 2014
43   *The Annual Report 2013/14 of The Public Services Ombudsman for Wales*

3.56 Instead of going down the route of formal complaints, many concerns can be addressed informally within services. This is good practice as it can deal with matters quickly. Our work has found that not all staff are confident in managing informal resolution of complaints and few have received any specific training to support them in this role. There are also inconsistencies in the way that informal complaints are recorded and reported within organisations.

Concerns from staff

3.57 In 2013, NHS Wales introduced an *All-Wales Raising Concerns* (Whistleblowing)' policy[44]. The policy sets out the procedure for staff to follow when raising concerns and encourages employees to report issues, advocating a culture of openness.

3.58 Audit work has noted limited use of the processes set out in the *Raising Concerns* policy, with staff mainly reporting concerns through line management arrangements or other mechanisms. This makes it difficult to keep a corporate record of concerns and analyse trends and common themes.

3.59 This finding is likely to reflect a need to promote greater awareness of the *Raising Concerns* policy amongst staff. It also probably reflects a general reticence on the part of staff to go down the formal whistleblowing route. In recognition of this, many NHS bodies have introduced less formal mechanisms such as reporting 'hotlines' in an attempt to make it easier for staff to raise concerns.

3.60 In general NHS bodies are working hard to encourage staff to report concerns and raise reports on errors, near misses and incidents. This is reflected in the increasing number of reported incidents within some NHS bodies. However, feedback from the last NHS staff survey[45] indicates that whilst a significant majority of staff are inclined to report concerns, significantly less have confidence that their employer will take the necessary action to prevent the problem recurring

3.61 In overall terms there is still more work to be done by NHS bodies to create a culture in which staff feel comfortable to raise concerns. This on-going work needs to embrace the guidelines produced by regulatory bodies such as the General Medical Council and the Nursing and Midwifery Council which highlight the professional duty on clinical staff to raise any concern about the quality or safety of care to patients. In this context, it is of note that the recent independent review of complaints handling in NHS Wales recommended that the rule of 'lawful candour' should be formally placed on the NHS in Wales, and that this should be a corporate duty and should not rest on the shoulders of individuals.

44   Welsh Government, All Wales Raising Concerns (Whistleblowing) Policy, July 2013. *An addendum to the approved policy accounted for the legislative changes which came into effect 25 June 2013 and a full review of the policy is planned for 2014*
45   bmg research, *NHS Wales Staff Survey 2013 – National Overview*, 2013. http://wales.gov.uk/topics/health/publications/health/reports/survey/?lang=en

Thematic analysis and learning

3.62 NHS bodies can demonstrate they are learning lessons from patient feedback and concerns within specific service areas, but these lessons are often not routinely shared more widely within the organisation to prevent repetition of the same issues in different locations. In addition, individual staff who have reported concerns or incidents have indicated that they do not consistently receive feedback about actions taken and improvements made as a result of their reports.

3.63 In general approaches for capturing, analysing and reporting patient experience at an organisational level are yet to be fully developed and a more systematic approach to learning lessons is needed. At present there is limited central thematic analysis and triangulation of patient experience measures which is a barrier to gaining wider organisational perspectives on patient experience and thematic learning.

Self-declarations and public reporting

3.64 There is a requirement for NHS bodies to provide assurance to the public on their organisations' performance and the quality and safety of the services provided. There is also a commitment to improving transparency and accountability for service quality and patient experience throughout NHS Wales. The culture within NHS bodies is generally one of increasing candour and openness, although self-declarations and public reporting are not yet providing consistent and rounded assurances to the public in an accessible way. Some commentary on the main forms of self-declaration and public reporting are provided in the following paragraphs. It should also be noted that health boards are increasingly looking to use a range of different public engagement activities to communicate with their local populations in ways which extend beyond the traditional reporting mechanisms set out below.

Annual reporting

3.65 Annual reporting is the principal mechanism used to formally provide assurance to the public, and includes an annual report, with separate governance and quality statements. In accordance with Welsh Government guidance on annual reporting, the AGS accompanies the annual statement of accounts published in June each year, while the annual report is published in September together with the AQS. Audit work examining NHS bodies' Annual Reports has not identified any significant concerns, in that our main findings on annual reports are:

  a   all NHS bodies routinely meet their requirements to produce and publish their Annual Report by 30 September each year;

  b   the Summary Financial Statements contained in Annual Reports are consistent with the full audited financial statements; and

  c   most organisations appropriately describe their successes and challenges for any given year.

Annual Governance Statements

3.66 The AGS is intended to demonstrate publicly the management and control of resources and the extent to which the NHS body complies with its own governance requirements, including how the effectiveness of governance arrangements have been monitored and evaluated. It is intended to bring together in one place all disclosures relating to governance, risk and control.

3.67 NHS bodies in Wales met the minimum requirements for producing and publishing an AGS, although there is opportunity to make greater use of the AGS as an iterative tool to underpin organisational governance, as opposed to just complying with an annual requirement to produce one. As a public report, clearer explanation of the purpose of the AGS could be expected. Many organisations include lengthy description of the organisation (which potentially duplicates the annual report), perhaps at the expense of providing a fuller description of governance arrangements, issues arising and how they are being dealt with. Other key findings in relation to AGSs are as follows:

a   all NHS bodies describe their committee structure and attendance records, but outlining of the issues considered by the Board and committees is patchy;

b   organisations successfully describe the work of internal audit, capital audit, counter fraud services and any other independent assurance providers;

c   high level information from self-assessment of governance and accountability against Standard 1 of *Doing Well, Doing Better* is included, although detail on the process of internal scrutiny and challenge of the self-assessment is rarely included;

d   issues such as equality, NHS pension scheme, civil contingency, and reference to ministerial directions are fully covered although these are mainly standard template disclosures; and

e   the summary of key risks and mitigations is not detailed and some NHS bodies simply provide a link to the risk register.

Annual Quality Statements

3.68　The AQS is intended to provide the public with information and assurance on the quality and safety of services. Auditors' review of the first set of AQSs produced in 2013 identified differences in the degree of candour in describing the quality of services, the risks and the actions being taken to improve. Some NHS bodies very clearly identified service quality successes, pressures and the difficulties experienced in the year, while the tone, style and content of others suggested less transparency.

3.69　The AQS has yet to become a fully embedded governance tool, integrated into quality assurance frameworks and adopted as an assurance process within operational divisions and localities. That said, NHS Wales has been keen to learn from the first year of AQSs. A national learning event, organised by the Welsh Government was held in January 2014. The event shared the learning from a peer review of AQSs undertaken across NHS Wales, as well feedback from the Wales Audit Office and the Older People's Commissioner. Building on this learning, the Welsh Government produced practical guidance for 2014 to help NHS bodies improve the quality, accessibility, and application of the AQS process. A review of the AQS's produced in 2014 found that:

a　all NHS bodies published their AQS within the required timeframe, although there was significant variation in the format, style and length;

b　NHS bodies again struggled to achieve a balance of detail, length and readability and most were overly technical and not sufficiently 'public facing' in their style; and

c　organisations were reasonably effective at providing an overview of quality arrangements for their locally provided services but most health boards were not effective at defining quality governance for services commissioned from partners.

3.70　The AQS has the potential to become an increasingly important tool for NHS bodies to demonstrate candour and transparency, as well as to celebrate successes. The findings of audit work to date, however, indicate that there is much still to do in order for these reports to achieve their desired aim.

Appendices

Appendix 1 – Other hosted organisations
in NHS Wales

Appendix 2 – Health Board and NHS
Trust Board Committees

Appendix 3 – Health Board
organisational structures

Appendix 1 – Other hosted organisations in NHS Wales

National Specialist Advisory Group for Cancer (NSAG)

The advisory group, otherwise known as the Cancer NSAG, is an all-Wales organisation hosted by Velindre NHS Trust. The Cancer NSAG provides clinical leadership and aims to add value for health boards and trusts by providing expert advice 'once for all' wherever possible.

The group is a statutory advisory committee to the Welsh Government and provides all-Wales specialist advice on cancer in Wales to the Minister, Welsh Government and NHS Wales.[46] It undertakes work commissioned by the Welsh Government and NHS Wales bodies as set out in a service level agreement with the Welsh Government.

The group has its own executive with a Chair and Vice Chair. The constitution of the Cancer NSAG sets out its status, remit and terms of reference.[47]

National Collaborating Centre for Cancer (NCC-C)

This body is hosted by Velindre NHS Trust and is one of five collaborating centres funded and commissioned by NICE. Its role is to develop evidence-based clinical guidelines for the NHS in England, Wales and Northern Ireland on treating and caring for people with cancer.

It has its own management board which: monitors the operating of NCC-C according to the contract between the centre and Velindre; appoints a Director of NCC-C; approves and reviews guidelines; and ensures sound financial governance[48].

National Institute for Social Care and Health Research Clinical Research Centre (NISCHR CRC)

The NISCHR CRC was established in 2010 as part of the research infrastructure for Wales. It is funded by the National Institute for Social Care and Health Research and the Welsh Government, is hosted by Velindre NHS Trust via a sub-contract from Cardiff University, and incorporates the Wales Cancer Research Network.

46   http://www.wales.nhs.uk/sites3/documents/322/Cancer_NSAG_Terms_of_Reference_June_2012.pdf
47   http://www.wales.nhs.uk/sites3/documents/322/Cancer_NSAG_Terms_of_Reference_June_2012.pdf
48   http://www.wales.nhs.uk/sites3/page.cfm?orgid=432&pid=12490

Appendix 2 – Health Board and NHS Trust Board Committees

Standing Orders for Health Boards and NHS Trusts require Boards to establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, Boards must establish Committees which cover quality and safety, audit, information governance, charitable funds, remuneration and terms of service and (where applicable), Mental Health Act requirements.

	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan University Health Board	Betsi Cadwaladr University Health Board	Cardiff and Vale University Health Board	Cwm Taf University Health Board	Hywel Dda University Health Board	Powys Teaching Health Board	Welsh Ambulance Services NHS Trust	Public Health Wales NHS Trust	Velindre NHS Trust
Quality and Safety *1	✓	✓	✓*	✓	✓	✓	✓	✓	✓	✓
Audit Committee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Information Governance *2	✓*	✓	✓*	✓*	✓*	✓*	✓	✗*	✓	✓
Charitable Funds *3	✓	✓	✓	✓	✓	✓	✓	✓	✓*	✓
Remuneration and Terms of Service *4	✓*	✓*	✓	✓	✓	✓	✓*	✓	✓	✓
Mental Health	✓	✓	✓	✓	✓	✓	✓	n/a	n/a	n/a
Integrated Governance *5	✗	✗	✓	✗	✓	✓	✗	✗	✗	✗
Finance and Performance *6	✓	✓	✓*	People, Performance and Delivery Committee	✓	✓*	✓	Finance and Resources Committee	✗	Planning and Performance Committee
Strategy and Planning *7	✓	✓	✓*		✗	✓	✗		✗	
Workforce and Organisational Development *8	✓	✓	✗		✗	✓*	✓		✗	✓

* Denotes where an aspect of Board business is covered and subject to scrutiny by an alternative Board Committee as set out in the footnotes

1 Quality and Safety: Betsi Cadwaladr: quality and safety is a sub-committee of the Integrated Governance Committee.
2 Information Governance: Abertawe Bro Morgannwg: sub-committee of Quality and Safety Committee; Betsi Cadwaladr: covered under Integrated Governance Committee; Cardiff and Vale: sub-committee of People, Performance and Delivery Committee; Cwm Taf: sub-committee of Corporate Risk Committee; Hywel Dda: sub-committee of Integrated Governance Committee; Welsh Ambulance Services NHS Trust: considered by Quality and Patient Experience & Safety Committee.
3 Charitable Funds: Public Health Wales NHS Trust's charitable funds are managed by Velindre NHS Trust's Charitable Funds Committee.
4 Remuneration and Terms of Service: Abertawe Bro Morgannwg and Powys: part of Workforce and Organisational Development Committee.
5 Integrated Governance: Abertawe Bro Morgannwg: Considered as part of a Chairs Advisory Group comprising Chairman and Committee Chairs
6 Finance and Performance: BCU: Integrated Governance Committee has a finance and performance sub-committee; Welsh Ambulance Services NHS Trust: scrutiny on specific elements of performance will be undertaken by the most appropriate committee.
7 Strategy and Planning: Betsi Cadwaladr: sub-committee of the Integrated Governance Committee.
8 Workforce and Organisational Development: Betsi Cadwaladr: workforce activity monitored via Finance and Performance sub-committee, and workforce strategy via Strategy, Planning and Partnerships sub-committee; Hywel Dda: sub-committee of Integrated Governance Committee; Cwm Taf: Finance and Performance Committee being developed into a People, Finance & Performance Committee: Public Health Wales: a 'Developing the Organisation' committee was established in 2014 for a time-limted period.

Appendix 3 – Health Board organisational structures

Health Board	Organisational structures – summary description	Acute hospital sites[1]	Acute hospital site management and accountability arrangements[2]	Status of organisational structure
Abertawe Bro Morgannwg	Clinical directorates operate across the Health Board for the following services: • Surgical • Regional • Clinical support services • Women and child health • Musculoskeletal • Cardiothoracic • Learning disability • Mental Health In addition, three geographical 'localities', coterminous with Local Authority areas, are responsible for primary and community care services. All directorates and localities operate triumverate[3] leadership and management arrangements, and report to the Chief Operating Officer.	4	Primary accountability for clinical services is via directorate management arrangements. Hospital site managers for day-to-day operational matters. A site-specific operational management structure was introduced at the Princess of Wales hospital in 2014. This model introduced a hospital management team led by a hospital Director, and an associate Medical Director and associate Director of Nursing for the hospital.	A new structure is to be implemented in 2015, made up of six delivery units: • a primary and community care delivery unit; • a mental health and learning disabilities delivery unit; and • four acute hospital units. Each unit will be led by a Service Director, unit Medical Director and Unit Nurse Director.
Aneurin Bevan	A number of operational divisions operate across the Health Board. The divisions are aligned to the following pathways: • Scheduled care • Unscheduled care • Family and therapy services • Mental health and learning disabilities There are also separate divisions for community services and for primary care, with sub-division arrangements aligned with the five Local Authority areas. All divisions operate triumvirate management arrangements and report to the Chief Operating Officer.	2	Primary accountability for clinical services is via divisional management arrangements. Hospital site managers for day-to-day operational matters.	No recent or planned changes.

1   Excludes mental health and community hospitals.
2   Individual hospital site management arrangements are in place in each health board but these are variable in terms of structure, reporting lines and accountabilities.
    A notable exception is the Princess of Wales Hospital which has a site-specific operational management structure.
3   Leadership is provided through a triumvirate of a Clinical Director, Manager and Senior Nurse.

Health Board	Organisational structures – summary description	Acute hospital sites	Acute hospital site management and accountability arrangements	Status of organisational structure
Betsi Cadwaladr	A new organisational structure will be implemented in 2015 based around: • a Secondary Care division (operating as 'one hospital on three sites'); and • three Area Teams for primary and community care, each coterminous with two Local Authorities; and • a Mental Health Division. The reporting lines of the Area Teams, the Secondary Care and Mental Health divisions are to the Chief Operating Officer. Triumvirate arrangements will be in place within each area team and division. A total of nine Clinical Divisions will operate across the Health Board. Five Clinical Divisions will sit within the Area Team part of the structure with a line of accountability for line management, service and budgetary performance to the Area Directors as follows: • Area 1: Medicines Management and Therapies • Area 2: Medical specialities (which do not generally require inpatient bed provision) and Elderly medicine • Area 3: Children and Young People The remaining four Clinical Divisions will sit within the secondary care part of the structure: • Surgery, dental, anaesthetics, scheduled care • Cancer and clinical support • Medicine and unscheduled care • Women's and access	3	The new structure will include three Hospital Site Directors each heading up a Hospital Management Team. Each Hospital Site Director will also have accountability for one or two of the Clinical Divisions that sit within the wider secondary care division.	New structure being implemented during 2015.

Health Board	Organisational structures – summary description	Acute hospital sites	Acute hospital site management and accountability arrangements	Status of organisational structure
Cardiff and Vale	The organisational structure is based around 'Clinical Boards' covering the following areas: • Clinical diagnostics and therapeutics • Children and women • Surgery • Medicine • Specialist services • Primary, community and intermediate care • Mental health • Dental The Clinical Board for primary, community and intermediate care contains 'locality' based sub-divisions aligned with Local Authority areas. All Clinical Boards operate triumvirate management arrangements and report to the Chief Operating Officer.	2	Accountability for clinical services is via the relevant Clinical Board. For non-clinical issues, there are site managers allocated within the operational services functions. In addition, each Clinical Board has a dedicated estates liaison officer and staff have access to the estates call centre (both functions sit within the Planning Directorate).	No recent or planned changes.
Cwm Taf	Clinical directorates operate across the Health Board and report to the Chief Operating Officer. Directorates comprise: • Obstetrics and gynaecology • Children and young people • Acute medicine and A&E • Radiology • Pathology • General surgery and urology • Anaesthetics, Critical care and theatres • Head and neck In addition, a mental health directorate, child and adolescent mental health service (CAMHS) and four geographical 'localities' with locality directors (responsible for primary and community care services) report to the Director of primary community and mental health, although localities, which includes therapies, are the responsibility of the Chief Operating Officer. All directorates and localities operate within triumvirate management arrangements.	2	Primary accountability for clinical services is via the clinical directorates. There are two hospital site based Heads of Nursing, one at Prince Charles Hospital, and the other at the Royal Glamorgan Hospital. They both act in a 'Matron' type role and have the ability to deploy resources and manage clinical services on a day-to-day basis across the whole site.	No recent or planned changes.

Health Board	Organisational structures – summary description	Acute hospital sites	Acute hospital site management and accountability arrangements	Status of organisational structure
Hywel Dda	Clinical divisions operate across the Health Board, aligned to the following service pathways: • Scheduled care • Unscheduled care • Women and children In addition, three county-based divisions, coterminous with Local Authority areas, are responsible for primary and community care services. A mental health division operates across the Health Board and covers both acute and community services. All divisions operate triumvirate management arrangements and report to the Chief Operating Officer via the Acute Services Director or a County Director (as appropriate). Note: the arrangements described are subject to change pending the findings of an external governance review commissioned by the Health Board.	4	Primary accountability for clinical services is via the clinical divisions. General managers for scheduled, unscheduled and women and children divisions hold site-based responsibilities for individual acute hospitals.	The current model was introduced in 2014. The previous model was geographical, with arrangements spanning primary, community and hospital-based services organised on a county basis.

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