Audit, Risk & Assurance Committee

Tue 21 March 2023, 10:00 - 12:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_21Mar2023.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 31 January 2023 for approval

Attached *Chair*

ARA_Item_1.3_Unconfirmed_Minutes_31Jan2023.pdf (11 pages)

1.4. Committee Action Log

Attached *Chair*

ARA_Item_1.4_Action Log_Mar 23.pdf (3 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

Attached *Director of Finance and IT*

ARA_Item_2.1_Application for Single Tender Waiver Mar 23.pdf (3 pages)

2.2. Approach to 2022-23 Annual Report and Annual Accounts

Director of Finance and IT and Director of Corporate Governance and Board Secretary

ARAC_Item_2.2_Approach to 22-23 Annual Accounts ARA 21MAR23.pdf (13 pages)

2.3. Internal Audit Plan 2023-24

Attached *Internal Audit*

ARA_Item_2.3_Powys THB Draft Internal Audit Plan 2023-24 Cover.pdf (3 pages)
ARA_Item_2.3a_Powys THB Draft Internal Audit Plan 2023-24.pdf (30 pages)

2.4. External Audit Plan 2023-24

Attached *External Audit*

ARA_Item_2.4_2022-23 Powys THB Outline NHS Audit Plan.pdf (10 pages)
ARA_Item_2.4a_NHS covering letter final.pdf (2 pages)
ARA_Item_2.4b_NHS_letter_final_eng.pdf (7 pages)

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Internal Audit Progress Report 2022-23

Attached *Head of Internal Audit*

- ARA_Item_3.1_Internal Audit Progress Report March 23 Cover.pdf (3 pages)
- ARA_Item_3.1a_Internal Audit Progress Report March 23.pdf (11 pages)

3.2. Internal Audit Review Reports: a) Therapies and Health Sciences Professional Governance Structure (Reasonable Assurance) b) Incident Management (Reasonable Assurance)

Attached *Head of Internal Audit*

- ARA_Item_3.2a_Professional Governance Structure - Final Internal Audit Report.pdf (17 pages)
- ARA_Item_3.2b_PTHB-2223-06 Incident Management Final Internal Audit Report.pdf (18 pages)

3.3. External Audit Structured Assessment

Oral *External Audit*

3.4. External Audit Progress Report 2022-23

Attached *External Audit*

- ARA_Item_3.4_Audit Wales ARAC Update March 2023.pdf (12 pages)

3.5. Post Payment Verification Update and Workplan 2023-24

Post Payment Verification Officer/Director of Finance and IT

- ARA_Item_3.5_PPV Progress Report.pdf (4 pages)
- ARA_Item_3.5a_Powys Audit report Apr 2022 - Mar 2023 Anonymised.pdf (4 pages)

3.6. Audit Recommendation Tracking

Attached *Director of Corporate Governance and Board Secretary*

- ARA_Item_3.6_Audit Recommendations_Report_March 2023 FINAL.pdf (11 pages)
- ARA_Item_3.6a_Appendix_D_Internal Audit Recommendations OUTSTANDING.pdf (2 pages)
- ARA_Item_3.6b_Appendix_E_IA COMPLETED since the previous report.pdf (3 pages)
- ARA_Item_3.6c_Appendix_F_IA Recommendations NOT YET DUE for Implementation.pdf (2 pages)
- ARA_Item_3.6d_Appendix_G_EA that remain OUTSTANDING.pdf (1 pages)
- ARA_Item_3.6e_Appendix_H_External Audit Recs NOT YET DUE for Implementation.pdf (1 pages)
- ARA_Item_3.6f_Appendix_I_EA COMPLETED since the previous report.pdf (2 pages)

3.7. Annual Governance Programme Reporting

Director of Corporate Governance and Board Secretary

- ARA_Item_3.7_Annual Governance Programme_Mar23-cover.pdf (3 pages)
- ARA_Item_3.7a_AGP 2022-23 Q3.pdf (13 pages)

3.8. Welsh Health Circular Tracking

Attached *Director of Corporate Governance and Board Secretary*

- ARA_Item_3.8_Welsh Health Circulars_February_2023 final.pdf (3 pages)
- ARA_Item_3.8a_Appendix 1_WHCs and MD that remain OUTSTANDING.pdf (4 pages)
- ARA_Item_3.8b_Appendix 2_WHCs Implemented since previousreport.pdf (1 pages)

3.9. Register of Interests

Attached *Director of Corporate Governance and Board Secretary*

ARA_Item_3.9_Delaration of Interests_March2023 final.pdf (4 pages)
ARA_Item_3.9a_Appendix_1_Board Members DoI summary 2022-23 final.pdf (2 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

4.1. Review of Committee Programme of Business

Attached *Director of Corporate Governance and Board Secretary*

ARA_Item_4.1_Committee Work Programme_2022-23.pdf (4 pages)

10:00 - 10:00
0 min

5. OTHER MATTERS

Chair

5.1. Items to be brought to the attention of the Board and other Committees

Chair

5.2. Any other urgent business

Chair

5.3. Date of next meeting: Tuesday 16 May 2023, 10am

Chair

The Chair, with advice from the Director of Corporate Governance and Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

5.4. Internal Audit Review Report: Cyber Security

Circulated to Members *Head of Internal Audit/Director of Finance and IT*

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 21 MARCH 2023
10:00 – 12:00
VIA MICROSOFT TEAMS

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA

Time	Item	Title	Attached /Oral	Presenter
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the Previous Meeting held 31 January 2023	Attached	Chair
	1.4	Audit, Risk & Assurance Committee Action Log	Attached	Chair
	2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
10:10	2.1	Application of Single Tender Waiver	Attached	Director of Finance and IT
10:20	2.2	Approach to 2022-23 Annual Report and Annual Accounts	Attached	Director of Finance and IT and Director of Corporate Governance and Board Secretary
10:30	2.3	Internal Audit Plan 2023-24	Attached	Internal Audit
10:40	2.4	External Audit Plan 2023-24	Attached	External Audit
	3	**ITEMS FOR ASSURANCE**		
10:45	3.1	Internal Audit Progress Report 2022-23	Attached	Head of Internal Audit
10:50	3.2	Internal Audit Review Reports: a) Therapies and Health Sciences Professional Governance Structure (*Reasonable Assurance)* b) Incident Management (*Reasonable Assurance)*	Attached	Head of Internal Audit

11:00	3.3	External Audit Structured Assessment	Oral	External Audit
11:05	3.4	External Audit Progress Report 2022-23	Attached	External Audit
11:10	3.5	Post Payment Verification Update and Workplan 2023-24	Attached	Post Payment Verification Officer/Director of Finance and IT
11:15	3.6	Audit Recommendation Tracking	Attached	Director of Corporate Governance and Board Secretary
11:20	3.7	Annual Governance Programme Reporting	Attached	Director of Corporate Governance and Board Secretary
11:25	3.8	Welsh Health Circular Tracking	Attached	Director of Corporate Governance and Board Secretary
11:30	3.9	Register of Interests	Attached	Director of Corporate Governance and Board Secretary
	4	**ITEMS FOR DISCUSSION**		
11:35	4.1	Review of Committee Programme of Business	Attached	Director of Corporate Governance and Board Secretary
	5	**OTHER MATTERS**		
	5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
	5.2	Any Other Urgent Business	Oral	Chair
	5.3	Date of the Next Meeting: Tuesday 16 May 2023 at 10.00, Microsoft Teams		

The Chair, with advice from the Director of Corporate Governance and Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

11:45	5.4	Internal Audit Review Report: Cyber Security	Circulated to Members	Head of Internal Audit/Director of Finance and IT

Key:

	Governance & Assurance
	Internal & Capital Audit
	External Audit
	Anti-Fraud Culture

Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

However, considering the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is considering plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance/Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Helen Bushell, Director of Corporate Governance/Board Secretary, helen.bushell2@nhs.wales.uk).

In addition, the Board will publish a summary of meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 23 JANUARY 2023 VIA MICROSOFT TEAMS

Present:

Mark Taylor	Independent Member – Capital and Estates (Committee Chair)
Rhobert Lewis	Independent Member – General
Ronnie Alexander	Independent Member – General
Tony Thomas	Independent Member – Finance

In Attendance:

Pete Hopgood	Director of Finance and IT
Carol Shillabeer	Chief Executive
Ian Virgil	Head of Internal Audit
Sarah Pritchard	Head of Financial services
Bethan Hopkins	External Audit
Alice King	External Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	Internal Audit
Sharon Edwards	Internal Audit
Matthew Evans	Counter Fraud
Kirsty James	Counter Fraud
Helen Bushell	Director of Corporate Governance and Board Secretary

Committee Support

Elizabeth Patterson	Interim Head of Corporate Governance

Apologies

None

ARA/22/097	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. There were no apologies for absence.
ARA/22/098	**DECLARATIONS OF INTEREST** The Committee Chair INVITED Members to declare any interests in relation to the items on the Committee agenda. None were declared.
ARA/22/099	**MINUTES OF THE MEETINGS HELD 15 NOVEMBER 2022** The minutes of the meetings held on 15 November 2022 were RECEIVED and AGREED as being a true and accurate record subject to the following amendment on page 3: *Was Director of Finance and IT assured that procurement process in relation to POW2223032 had been proper and correct given the ~~abscondment~~* termination *of the first ~~contractor~~* contract *resulting in appointment of the second contractor, resulting in an increased cost of 30%?*
ARA/22/100	**MATTERS ARISING FROM PREVIOUS MEETINGS** *Did the health board lose any money when the first contract in relation to POW2222303 was terminated?* The Head of Financial Services confirmed that no financial loss occurred as a result of the change in contractors on this project.
ARA/22/101	**COMMITTEE ACTION LOG** The Committee received and NOTED the action log. The following actions were discussed by the Committee: • ARA/22/034 (Register of Contracts), ARA/22/047 (Inclusion of maintenance costs in contracts) and ARA/22/048 (Losses and Special Payments trend analysis): Included in the agenda for 31 January 2023. Actions Completed. • ARA/22/069 (IT Infrastructure and Asset Management Report (Limited Assurance)): It was confirmed that a paper was due to be provided to Delivery and Performance Committee in February 2023.
ARA/22/102	**APPLICATION OF SINGLE TENDER WAIVER** The Head of Financial Services presented the following application for three single tender waivers received during the period of 1 November 2022 and 31 December 2022:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223033	Quote	Dekomed	Maintenance of Dental Equipment	Sole Supplier	16/11/2022	£20,880	3 Years	Part - Retrospective	A1
POW2223035	Tender	Protect Plus Ltd	Maintenance of Anti Ligature Fixtures and Fittings	Sole Supplier	16/11/2022	£25,222	3 Years	Prospective	A2
POW2223036	Quote	Clearhealth Ltd	Occupational Health Physician Services	No NHS Provision available and clinical need	17/11/2022	£18,750	7 Months	Prospective	A3

Independent Members welcomed the improved timeliness of Single Tender Waivers coming to Committee.

It was agreed that a Summary of Single Tender Waivers would be included annually on the Committee Work Programme.
Action: Director of Corporate Governance and Board Secretary.

Independent Members sought assurance by asking the following question:
Is the procurement process sufficient to ensure that maintenance costs are included initially, thereby avoiding the need for later single tender waivers in relation to maintenance costs?
The Head of Financial Services confirmed that new contracts now included maintenance costs and single tender waivers for maintenance reasons would therefore decrease over time as new contracts were agreed.

The Committee RATIFIED the use of Single Tender Waivers in respect of 3 items during the period of 1 November 2022 and 31 December 2022.

ARA/22/103	**INTERNAL AUDIT PROGRESS REPORT 2022-23** The Head of Internal Audit presented the report which provided an overview of the progress against the 2022-23 Internal Audit Plan. The following matters were highlighted for the Committee's attention: • since the last meeting of the Committee eight audits had been finalised; • five audits were work in progress with a further five at planning stage, leaving 2 audits yet to commence; • it was expected that all planned audits would be completed within the year; and • of the 14 audits completed there were only 2 with Limited Assurance which indicated that the year-end report from Internal Audit would be positive The Head of Internal Audit noted that whilst the management response times performance indicator remained green, there had been delays in receiving a management response in two recent cases. This was an early warning flag for the health board. The 2023-24 Internal Audit Plan was in development with meetings taking place between Internal Audit and Executive Directors. The team will also meet with the Chief Executive and Director of Corporate Governance and Board Secretary following which the plan will be shared with the Executive Team and Independent Members. The Committee DISCUSSED and NOTED the update.
ARA/22/104	**INTERNAL AUDIT REPORTS** *a) Looked After Children (Substantial Assurance)* The Committee received the report which gave substantial assurance that effective processes are in place to ensure the Looked After Children (LAC) Health Assessments are appropriately completed for all relevant Looked After Children in accordance with the requirements of the Framework. Independent Members sought assurance by asking the following questions: *Section 2.28 notes that there are 'a number of factors which impact on the LAC team's ability to complete Health Assessments within the timescales set out in the framework. Often these factors are external to the health boards arrangements and relate to roles and responsibilities of the local authority…' Can assurance be given that the health board are doing all within their ability to ensure that the delay is not because of the health board's actions, and can assurance be given that the health board is working closely with the local authority to ensure that Health Assessments are undertaken in a timely manner?* The Chief Executive advised that there were challenges in getting all agencies available to undertaken assessments exacerbated by problems with

social worker recruitment. There is an additional complication where Looked After Children are placed in Powys by other local authorities where delays in notification to the health board by the placing authority may occur.

b) Cancer Services – Access to Symptomatic Fit (Substantial Assurance)
The Committee received the report which provided substantial assurance that the planned actions to allow improved access to symptomatic FIT were being effectively delivered.

c) Women and Children's Services (Substantial Assurance)
The Committee received the report which provided substantial assurance on the adequacy of the systems and controls in place within the School Nursing and Health Visiting departments of the Women and Children's Service in respect of governance, workforce management, risk management and financial management arrangements.

d) Machynlleth Hospital (Reasonable Assurance)
The Committee received the report which provided reasonable assurance on the delivery and management arrangements in place to progress the Machynlleth Reconfiguration project, and the performance against delivery objectives.
The project had remained in budget, but delivery had been delayed by 13 weeks. A number of key risks were outlined in the report.

Is the cost of the six week delay mentioned in 2.6 of the report borne by the health board or contractor?
The cost will be borne by the contractor with the health board only incurring additional costs in relation to employing a contract manager for the additional period.

2.24 of the report mentions spending outside Standing Orders. Further information is requested to understand why this happened and for assurance lessons have been learnt to ensure that this does not happen in the future.
The Chief Executive advised a review would be presented to Delivery and Performance Committee for assurance.
Action: Director of Environment

e) North Powys Wellbeing Programme (Reasonable Assurance)
The Committee received the report which provided reasonable assurance on an assessment of the health board's arrangement to take forward the North Powys Programme, including management of demand and capacity modelling and service capacity. Attention was drawn to one high priority matter relating to the need to finalise the 2022-23 Programme Plan, together with four medium priority matters.

What progress is being made with the Diagnostic programme?

The Chief Executive advised that it is intended to bring the Diagnostic Strategic Intent paper to Board in March 2023 in conjunction with the work on the Accelerated Sustainable Model.
Action: Director of Planning and Performance

Will the North Powys Wellbeing Programme Oversight group, which has not met for some time, be reinstated?
The Chief Executive confirmed the Oversight Group had not sat for some time and advised that an update would be brought to the Planning, Partnerships and Public Health Committee.
Action: Director of Primary, Community Care and MH

f) Charitable Funds (Reasonable Assurance)
The Committee received the report which provided reasonable assurance relating to the appropriate management and administration of Charitable Funds in line with relevant legislation and Charity Commission guidance.

g) *Workforce Futures (Reasonable Assurance)*
The Committee received the report which provided reasonable assurance that the Workforce Futures Strategic Framework has started to embed and is providing clear direction of the future work required to achieve the outcomes intended.

h) Welsh Language Standards (Limited Assurance)
The Committee received the report which provided limited assurance that the processes were in place within the health board to ensure compliance with the requirements of the Welsh Language Standards Act. Attention was drawn to the following five high and three medium priority matters identified:

- Service Group Action Plans (high)
- Monitoring of compliance with the action plans (high)
- Welsh Language policy (high)
- Monitoring and reporting on compliance (high)
- Welsh Language Annual Report (medium)
- Estates signage (medium)
- Staff awareness (medium)
- Level of risk (high)

It was confirmed the management response had accepted the recommendations.

How does the position identified within this report compare to the position in other health boards?
The Head of Internal Audit advised that anecdotally the organisation was not a huge outlier but was a little behind the position elsewhere.

The Chief Executive noted that the report findings had been accepted and would be followed up. Whilst there was only a small Welsh Language team in Powys this should not be a barrier to progress as elsewhere small teams had

	made good progress. Internal Audit would produce a follow-up report which would be brought to the Committee in the next year. The Committee received and NOTED the Internal Audit Reports.
ARA/22/105	**EXTERNAL AUDIT PROGRESS REPORT 2022-23** External Audit presented the item which provided an update on current and planned Audit Wales work. The Committee NOTED the following audits currently underway: • Orthopaedic services – follow-up; • Review of Unscheduled Care; • Structured Assessment; • Primary Care Services – a follow-up review to one undertaken in 2019 looking at capacity in primary care; and • Workforce Planning – the project brief was issued in November 2022, field work to be phased over the next few months It was confirmed that the Charitable Funds Audit had been completed. The Committee were advised that the timetable for the Full Audit of Financial Statements for 2022/23 was still to be agreed and would potentially be later than anticipated. A formal communication on the timetable was expected shortly. The Director of Finance and IT confirmed the Charitable Funds accounts had been submitted to the Charity Commission on the 31 January 2023. In relation the year end timetable it was understood that conversations were taking place between Welsh Government and Audit Wales. This is a significant issue as any change to the timetable will have a considerable impact on managing workloads. This would also impact on the production of the Annual Report. Independent Members sought assurance by asking the following questions: *Will the planned work on primary care include consideration of profile and capacity?* The External Auditor invited Committee Members to email specific requests regarding the content of planned audit work. External Audit drew attention to a number of NHS related and all-Wales summary reports, particularly in relation to Social Enterprise and poverty. The Committee DISCUSSED and NOTED the Report.

ARA/22/106	**EXTERNAL AUDIT REPORTS:** The Committee received and NOTED the following Audit Wales reports for information: *a) Review of Strategic Renewal Portfolio* This review was undertaken during the Winter 2021 omicron surge whilst staff were under huge pressure, and appreciation was noted for the time that staff gave to engage with auditors. Five recommendations were identified, and a management response has been received of which it is noted that two of the recommendations have not been accepted. Independent Members sought assurance by asking the following questions: *Why did the audit unusually conclude that the governance structures for this programme were unnecessarily large?* The External Auditor advised that when the review was undertaken the conclusion was that the work delivered in relation to renewal whilst broad, was limited and the governance arrangements whilst sufficient for this area of work could be utilised for other programmes. The Chief Executive thanked External Audit for undertaking the review. The fieldwork had commenced in November 2021 which had been a particularly challenging time for the organisation with events fast moving in relation to omicron with short notice surge arrangements and mass vaccination. The health board has focussed on recovery (which in the health board is described as renewal) the scope of which was significant, and perhaps not fully understood. There is a difference in view, with the health board's position that the governance arrangements covered a large part of the business. The report had been published in March 2022 and considerable changes have taken place since then. Welsh Government provided recovery ('renewal') money and a Core Group was established to support effective decision making. The focus has now moved to the production of the Integrated Medium Term Plan and the sustainability of approach. The Chair welcomed both the report and response and thanked the authors. The Committee DISCUSSED and NOTED the Report.
ARA/22/107	**EXTERNAL AUDIT STRUCTURED ASSESSMENT UPDATE** External Audit advised that the draft Structured Assessment would be provided to the health board in the next few days. The Committee NOTED the update.
ARA/22/108	**COUNTER FRAUD UPDATE** The Head of Counter Fraud presented the report noting that good progress on the annual plan had been made. The number of cases is lower than in previous years and cases are being closed more quickly. However, there is a bottleneck of prosecution cases with delays at Courts resulting from the

covid backlog, and Barrister strikes. In addition, the facility to undertake Police National Computer (PNC) checks is not available at present and although local Police colleagues may be able to provide a PNC it is not possible to proceed to prosecution in the absence of a PNC. It is expected that the ability to process a PNC will be available in the coming weeks.

Proactive Exercise – Gifts and Hospitality

The Local Counter Fraud Specialist presented the report outlining that compliance was good, although there was some confusion regarding how to comply with one method outlined in the report but easier methods taking place in practice, for example via Datix. The report recommended simplifying the process for recording gifts and hospitality and encouraging recording of declarations of interest on the Electronic Staff Record by linking it to the annual Performance Appraisal and Development Review (PADR).

The Director of Corporate Governance and Board Secretary thanked the Counter Fraud team for the report and would welcome an opportunity to discuss the findings.

Independent Members sought assurance by asking the following questions:
Why is Datix (an incident reporting system) is being used to record gifts?
The Local Counter Fraud Specialist explained that staff were recording compliments on Datix and then noting the gift in addition to the compliment.

The linking of declarations of gifts and hospitality to the annual PADR is welcome but it is necessary for completion of PADRs to be compliance for this to be successful.
The Head of Counter Fraud agreed and noted that the intention of including declarations of gifts and hospitality within the PADR process was to raise the profile of such declarations and thereby compliance.

Will the actual/perceived budgetary hole in Betsi Cadwalladr University Health Board (BCUHB) affect the way that the Counter Fraud Unit undertakes work in the future?
The Head of Counter Fraud confirmed that lessons would be learnt from the work undertaken in BCUHB in conjunction with external audit.

The Chair advised that he had requested a Lessons Learnt paper be brought to Committee in relation to the issues at BCUHB.

Whilst some fraud will always be undetected, can assurance be taken that the low number of cases reported are proportionate to the size of the organisation?
The Head of Counter Fraud advised that the next report would include benchmarking per 1,000 staff to aid understanding of the position. Direct comparator organisations are hard to find for this health board.

	The Head of Counter Fraud presented the Counter Fraud Investigations Update Report. *In respect of closed investigation INV/22/0490 – Overpayment of Child Care Voucher Scheme – were any issues identified from a procurement perspective?* The Head of Counter Fraud confirmed there had been no criminal wrongdoing, however, system changes have been put in place regarding the approval processes. Consideration will be given by the Counter Fraud team regarding undertaking a Proactive Exercise in this area. The Committee DISCUSSED and NOTED the Report.
ARA/22/109	**LOSSES AND SPECIAL PAYMENTS UPDATE REPORT** The Head of Financial Services presented the interim Losses and Special Payments Report covering the period 1 April 2022 – 31 October 2022, to which the Welsh Risk Pool Annual Review was appended at request of Committee. A supplementary appendix benchmarked claims activity in the health board against all Wales data. It was noted that reimbursements may not relate to the time of the original event as claims may span many years. In the case of clinical negligence, the health board is liable for the first £25k whilst GPs are fully indemnified. It was confirmed that the Audit, Risk and Assurance Committee are required to receive the financial information in respect of Losses and Special Payments. The Executive Team and Patient Experience, Quality and Safety Committee receive information on Concerns (incidents, complaints, and claims) from a quality and learning perspective. *Is it known why it appears that the health board are less successful than other health boards in Wales in rebutting negligence claims?* The Head of Financial Services noted that the health board, as a small commissioning organisation, had a different make-up to other health boards in Wales who were likely to receive many speculative claims which could be closed without damages. The Chief Executive advised that trends and lessons learnt would be included in a report to the Patient Experience, Quality and Safety Committee. **Action: Director of Nursing and Midwifery** The Committee DISCUSSED and NOTED the Losses and Special Payments Update Report.
ARA/22/110	**REVIEW OF COMMITTEE PROGRAMME OF BUSINESS** The Committee RECEIVED and NOTED the Committee programme of business. It was noted that the Audit Tracker had not been considered at this meeting due to the large number of Internal Audit reports which had been received. The Audit Tracker would next be considered at the March 2023 meeting.

	The Director of Finance and IT advised the Committee that the with final reporting timetable for the Annual Report yet been confirmed by Welsh Government there may be an impact on the Work Programme for 2023/24.
ARA/22/111	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Chair's Report to Board to reference the potential changes to the year-end reporting timetable.
ARA/22/112	**ANY OTHER URGENT BUSINESS** *Will the recent announcement in England of additional funding for beds and ambulances result in Wales receiving consequential funding?* The Director of Finance advised that this would result in consequential funding in the region of £56m for Wales. However, no information was available regarding the allocation of this funding by Welsh Government.
ARA/22/113	**DATE OF NEXT MEETING** 21 March 2023, 10:00, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(21 March 2023)

Minute	Date	Action	Responsible	Progress	Status
ARA/22/069	27 September 2022	The IT Infrastructure and Asset Management (Limited Assurance) would be taken forward to a meeting of the Delivery and Performance Committee for further discussion.	Director of Finance & IT	Paper provided to the Delivery and Performance Committee 28 February 2023. Delivery and Performance Committee to continue to monitor progress on this matter.	Transferred to Delivery and Performance Committee
ARA/22/102	31 January 2023	A summary of Single Tender Waivers to be included annually on the Work Programme	Director of Finance & IT	Added to the Work Programme for 2023/24.	
ARA/22/104a	31 January 2023	A review of the Machynlleth Hospital Development	Director of Environment	This issue arises due to the fact that the day to day approval levels for an AD are relatively low when they act as a Project	

				Director on a major capital project. This specific scheme is the largest PTHB has implemented to date. Approvals were required in a live project decision making. The approvals were all ratified by the SRO but for future projects learning will be applied to ensure the PD is able to sign off timely expenditure in a live project and this will be followed up and embedded by future SROs and wider appropriate colleagues when establishing project governance	
ARA/22/104b	31 January 2023	Diagnostic Strategic Intent paper to be considered at March 2023 Board as part of the Accelerated Sustainable Model	Director of Planning and Performance	To go to relevant Board	
ARA/22/104c	31 January 2023	An update on the North Powys Wellbeing Programme to be brought to the Planning, Partnerships and Public Health Committee	Director of Primary, Community Care and MH	Transferred to PPPH Committee Action Log	Transferred to PPPH Committee
ARA/22/109	31 January 2023	Trends and lessons learnt from rebutting negligence claims to be included in the	Director of Nursing and Midwifery	Transferred to PEQS Committee Action Log	Transferred to PEQS Committee

		Integrated Quality Report to the Patient Experience, Quality and Safety Committee			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 21st March 2023**
Subject:	**SINGLE TENDER WAIVERS**
Approved and presented by:	Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:

To seek the Audit, Risk and Assurance Committee's RATIFICATION of Single Tender Waiver requests made between 1 January 2023 and 28 February 2023.

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of three items during the period of 1 January 2023 and 28 February 2023 and consider additional information provided regarding the individual single tender document.

Ratification	Discussion	Information
✓		

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	×
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	×
	5. Timely Care	✓
	6. Individual Care	×
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements.

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its January 2023 meeting which covered the period from 1 November 2022 and 31 December 2022.

A summary of the use of Single Tender Action from 1 January 2023 and 28 February 2023 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223044	QUOTE	Cyted UK Ltd	Analysis and reporting of Cytosponge diagnostic tests	Sole Supplier	17/02/2023	£9,900	6 months	Prospective	A1

Please note due to an administrative error the STW register log for 2022/23 commenced on STW 2223029

Full details including supporting documentation has been shared with Committee members under confidential cover, given the potential for commercially sensitive information to be included.

From 1st January 2019 a Dun and Bradstreet Report is being undertaken by NWSSP Procurement Services to provide a report on financial standing of the proposed supplier including Director details and associated companies. This has been introduced to further strengthen governance of the Single Tender Waiver process. This is referenced in the procurement section of the form and the full report is reviewed by the Head of Financial Services and provided to the Chief Executive with the Single Tender Waiver Form to aid the decision-making process.

NEXT STEPS:

A report on use of Single Tender Waivers will be submitted to each Audit, Risk and Assurance Committee meeting. A nil report will also be reported if applicable.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

Audit, Risk and Assurance Committee	**Date of Meeting:21 MARCH 2023**
Subject:	**ANNUAL ACCOUNTS 2022/23** **Timetable and Principles for the Financial Methodology and Approach at Year End**
Approved and Presented by:	**Director of Finance and IT**
Prepared by:	**Head of Financial Services**
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an outline of the approach and principles to be adopted for completion of the 2022/23 Annual Accounts together with the planned approach to key financial areas.

RECOMMENDATION(S):

The Audit and Risk Assurance Committee is asked to:

- note the content of this report;
- note the planned approach to accounting areas including use of estimates where needed as outlined within the paper.

Ratification	Discussion	Information
✓		

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):			
Strategic Objectives:	1.	Focus on Wellbeing	×
	2.	Provide Early Help and Support	×
	3.	Tackle the Big Four	×
	4.	Enable Joined up Care	×
	5.	Develop Workforce Futures	×
	6.	Promote Innovative Environments	×
	7.	Put Digital First	×
	8.	Transforming in Partnership	×
Health and Care Standards:	1.	Staying Healthy	×
	2.	Safe Care	×
	3.	Effective Care	×
	4.	Dignified Care	×
	5.	Timely Care	×
	6.	Individual Care	×
	7.	Staff and Resources	✓
	8.	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Health Board has a statutory duty to complete and submit Annual Audited Accounts to Welsh Government. This paper is to inform the ARA Committee of the

work completed to date and the further steps required. Plus, the key methodology to be adopted in completing the Annual Accounts process.
DETAILED BACKGROUND AND ASSESSMENT:
The purpose of this paper is to update the Committee on the plans in place to close the Annual Accounts for the year ending 31 March 2023. This paper outlines the timetable and key dates for delivery of the Annual Accounts. This paper also highlights key financial assumptions and methodologies to be adopted and the impact of this on the Annual Accounts.
NEXT STEPS:
• Adherence to the timetable and approach as defined within the paper.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				

Risk Assessment:					
	Level of risk identified				
	None	Low	Moderate	High	
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

1. INTRODUCTION

1.1. The purpose of this paper is to provide the Audit Committee on the plans in place to close the Annual Accounts for the year ending 31st March 2023.

1.2. As well as the timetable and key dates for delivery of the Annual Accounts this paper will also highlight key financial areas and the approach adopted in Powys on the assessment of these and the impact of this on the Annual Accounts.

2. BACKGROUND

2.1. A very detailed and comprehensive closedown timetable with supporting guidance notes has been developed and made available to all staff within the Directorate via email.

2.2. Once the final version of the Manual for Accounts is received, which is expected this month, this will be saved on a shared drive within Directorate for staff reference where required.

2.3. The key dates and milestones from the main Annual Accounts Closure Timetable are summarised in the table below:

Annual Accounts Task	Deadline
Issue NHS Debtor Balance Statements to other NHS Wales bodies	5 April 2023
Sign off date for Agreement of NHS Wales Debtors & Creditors	12 April 2023
Issue Income transactions to NHS Wales bodies	13 April 2023
Sign off date for agreement of NHS Wales Income & Expenditure	20 April 2023
Finalise Health Board Outturn Position	11 April 2023
Close Health Board old year financial ledger	11 April 2023
Submit LMS to Welsh Government	21 April 2023

Annual Accounts Task	Deadline
Preparation of draft Accounts Senior Finance Team review	27 April 2023
Submission of Draft Accounts to Welsh Government	5 May 2023
Submission of Draft Accountability Report and Performance Overview (including Remuneration Report) to Welsh Government	12 May 2023
Submission of Audited Accounts	31 July 2023

2.4. To note these timescales are extended in comparison to 2021/22 due to an extended audit timeline that has been communicated to all NHS Wales bodies and details of this is included within the committee papers under the Audit Wales 22/23 Audit Plan.

3. GOVERNANCE AND RISK ISSUES

3.1. The Audit Committee meeting scheduled for Tuesday 16 May 2023, will receive the draft Annual Accounts, Accountability and Performance Report and the Remuneration Report.

3.2. A special meeting of the Audit Committee will need to be arranged in mid to late July 2023, once the audit resource timetable is provided to the THB by Audit Wales. This will be to review the full audited statements and reports, with a Board meeting to formally adopt them on shortly after. The deadline for submission of the approved audited accounts and associated reports to Welsh Government is indicated to be 31st July 2023.

3.3. In closing the accounts, the following key issues are drawn to the attention of the Committee and Audit Wales with regards to the technical accounting treatment that will be employed by Powys Teaching Health Board in closing the draft annual accounts.

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

A. CAPITAL ISSUES

i. De-recognition

The approach developed by the All Wales Technical Accounting Group (TAG) Capital Sub Group for use since 2009/10, where PTHB will require revaluations from the District Valuer where schemes completing in-year have works and fees costs exceeding £0.5m. Subject to completion of some schemes leading up to year-end there are 1 schemes that we anticipate will require revaluation this year.

ii. IFRS 16

Following its deferral in both 2020/21 and 2021/22 due to the COVID pandemic, International Financial Reporting standard (IFRS) 16 came into effect on 1st April 2022.

IFRS 16 provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value.

This standard effectively changes the accounting treatment of some leases from revenue transactions (off balance sheet) to capital transactions (on balance sheet) and will result in a significant number of changes to the accounts content and format.

B. PRIMARY CARE ACCRUALS

The format of the working papers for Primary Care Accruals will be the same as that used in previous years and will provide clear linkages and audit trails from the Annual Accounts back to the General Ledger.

The Health Board has reviewed the accounting methodologies used across the primary care accrual areas last year. This review has taken into consideration actual outturn values against accrual values and whether there have been any amendments to primary care contracts in year to determine whether any changes are required for 2022/23. The outcome of this work has concluded the following:

i. GMS Enhanced Services

Given the timescales allowed for practices to claim Enhanced Services, some of the claims may not be received until the following year, therefore, the HB is required to estimate the final out-turn. Prior to COVID the HB would review the latest claims from each practice for each enhanced service and estimate the final out-turn, by taking account of current or prior year trends (where seasonality impacts) on the given service.

Following a more complicated process for 2021/22 in which payments were based against a 2019/20 baseline, and a % threshold to deliver against, the process in 2022/23 has returned to an accrual based on predicted actual achievement. This will be based on best estimates and information available at M12.

ii. GMS QAIF (Quality Assurance and Improvement Framework)

Under the QAIF scheme, GP Practices achieve a certain level of points and these are multiplied by £x value per point (varies depending on practice weighted list size) to establish the payments due. QAIF years run from 1 October to 30 September, so the final achievement value for M7-12 of a given year is not known until the following December. Estimates are, therefore, required to drive the year end accrual.

Points to note for this year's formula:

- The point system changed mid-year in line with a more complex GMS settlement.
- From April to September the points available were consistent with FY21-22. QA/QI - 510, Access – 125, Total 635.
- From October to March the point available have now changed to QA/QI – 170, Access – 100, Total 170.
- The difference in funding from October to March has been transferred into the core GMS payments.

iii. Pharmacy Contract

No changes are proposed for the approach to calculating the accruals from 2021/22. Estimates will predominantly be an adjusted straight line, which includes any adjustments for additionality identified costs as part of the year end review.

iv. Primary Care Prescribing

Information on Prescribing costs is available two months in arrears, and therefore requires a level of estimation for year-end accruals. Historically, the Health Board has used the Prescribing Audit Report from NHS Wales Shared Services Partnership to support the estimation of year end accruals.

The Health Board has continued to utilise other NHS organisations estimates, and understand their prescribing patterns and trends, which has included the work of the NHS Business Service Authority in England, as well as Dispensing days analysis undertaken by other Health Boards in Wales. This is analysed alongside other information to provide greater insight on high-cost areas, including CAT M, NCSO and DOACs.

The continued growth, month on month in 2022/23 (3% average increase from April to December) has required the Healthboard to add cost growth trend forecasting to the analyses identified above when calculating a position to report.

The Health Board will review these forecasting methodologies at the time of accounts closure together with any additional supplementary information available and together with its Chief Pharmacist will take a view of an appropriate accrual.

C. RETROSPECTIVE CONTINUING HEALTH CARE CLAIMS (OMBUDSMAN PROVISION)

i. Background

At the start of 2011/12, the PTHB Ombudsman Nursing team was disbanded and all cases received prior to 15th August 2010 (Phase 1), were transferred to the All Wales Retrospective Continuing Health Care Team hosted by Powys Teaching Health Board (Powys HB), to be managed using a standardised All Wales approach.

During 2014, the Welsh Government launched an advertising campaign to draw the public's attention to the cut-off date for retrospective continuing NHS health care claims relating to the period 1st April 2003 to 31st July 2013 (Phase 3). Claimants needed to register their intent to claim by 31st July 2014, and no later than 31st December 2014 (later extended by Welsh Government to 31st January 2015), to provide evidence of their right to make the claim and proof of fees paid to the care home or domiciliary agency. The intent to claim and the supporting documentation had to be submitted to the All Wales Retrospective Review Team within Powys HB.

Financial responsibility for all post 2003 claims, regardless of when they were received, rests with the Health Board and pre 2003 cases with Welsh Government.

During 2019/20, the All Wales Retrospective CHC team were disbanded and any remaining phase 2 and phase 3 claims which had not been settled reverted to the management of the Powys Teaching Health Board.

Further annual publicity campaigns have resulted in the ability to claim for periods post July 2013. For phase 4 and subsequent phases, the average success rate will be continued to be used to make a reliable estimate for probable claims based on the average weekly rate. All phase 4,5 & 6 cases have now been settled. As at 31st March 2023 a provision will be provided for the phase 7 claims, currently recording 5 cases.

D. REPORTING ISSUES

i) Pension 6.3%

The recent revaluation of public sector pension schemes resulted in a 6.3% increase in the employer contribution rate for the NHS Pensions Scheme (14.38% to 20.68%).

A transitional approach was agreed with the Business Services Authority, whereby an employer rate of 20.68% will apply from 1 April 2019, however in 2019-20 the Business Services Authority will only collect 14.38% from NHS Wales bodies. Central payments have been made by Welsh Government for the outstanding 6.3% on behalf of NHS Wales bodies. This continues in 2022/23.

It is important that notional transactions are recorded in NHS Accounts to record the true costs of the pension contributions the bodies have incurred. Therefore, adjustments are made in the accounts for the 6.3% and a specific note is completed under Note 34 Other Information to explain the relevant accounting entries to the reader of the accounts. The amount to be included will be provided to the Health Board by Welsh Government but will be compared to the 14.38% contribution payable by Powys THB for reasonableness.

ii) Scheme Pays

In December 2019, Welsh Government confirmed that clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold would be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31st July 2021). The NHS employer would then make a contractually binding commitment to pay them a corresponding amount on retirement.

For the 2019/20 accounts no disclosure with regard to this policy was provided as the information to determine whether a provision or contingent liability was required was not available. For the 2020/21 accounts a narrative contingent liability note was disclosed detailing the scheme as insufficient information was available to support a provision. For the 2021/22 accounts a provision was required for the future costs of this commitment by NHS bodies. Welsh Government is working with the NHS Pensions Agency and Government Actuaries Department to identify the estimated costs for each health body and there will be a requirement for each health body to disclose a provision in the 2022/23 accounts. There will not be an impact to the financial performance of the health board as Welsh Government has advised that, as in 2021/22, the provision will be offset within the financial statement by a debtor to Welsh Government. This is similar to the process for the Welsh Risk Pool.

Last year, the provision included within health board accounts for the cost of Scheme Pays was considered to constitute an irregular expenditure and led to a qualification of the health board's accounts in respect of the regularity opinion. We understand that the Auditor General for Wales will be considering what may be required in respect of this this year.

E. MOVEMENT IN OTHER KEY PROVISIONS

I. Early Retirement Pension Provision / Permanent Injury

There has been a further change in the Discount Factors to be applied in line with the draft Manual for Accounts issued by Welsh Government in December 2022. This directs health boards to use 1.70% this year (-1.30% 2021/22). This will result in a financial cost reduction of £0.111M this year.

PTHB also account for the permanent injury provision in respect of a former member of staff of Health Authorities which were reorganised into Health Boards in April 2003. This provision although not material within the THB accounts is fully funded by Welsh Government and therefore any financial impact on movement of this provision year

on year is reimbursed to the Health Board via an allocation by Welsh Government so has no impact on the reported performance of the Teaching Health Board.

II. Defence Fee Provision for Probability 3 (possible) Successful Legal Claims

As is the case for previous years, to comply with the requirements of IAS 37: Accounting for Provisions, Welsh Government has issued guidance regarding the accounting treatment of defence fees for legal claims where the chance of success is deemed as possible (6-49% chance of success).

For the defence legal costs provision of claims within the possible category, the obligating event is a claim being received in respect of Clinical Negligence or Personal Injury.

It is probable, when considering the possible claims as a cohort, that this obligating event may lead to a future transfer of economic benefit in that the organisation may incur some costs in investigating the alleged claim. Therefore, a provision is required for the possible claims as a cohort and for which a reliable estimate can be made based on local information held for similar cases. The estimate cannot be made reliably on a claim-by-claim basis; rather the analysis of historical information covering a three-year period is used.

The table below shows the prescribed accounting treatment to be applied for all claims based on their probability of success:

Probability of Success of Claim	**Accounting Treatment**
Certain 95-100% Success	***Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports***
Probable 50- 95% Success.	***Defence Fee Provision at 100% of cost advised by Welsh Health Legal Services on their quantum reports***
Possible 6-49% Success	***Defence Fee Provision Required – Provision to be based on the Welsh Health Legal Services quantum reports -*** Organisations with numerous claims should base the provision on three years historical cost data. Note there may be different % values for clinical negligence and personal injury cases, and the % values will be calculated using the methodology agreed.
Remote 0- 5% success	***No provision or contingent liability required***

In 2021/22 the Health Board provided on the basis outlined in the table above with the percentages used to provide for probability 3 cases being 28% for Clinical Negligence cases and 56% for Personal Injury cases. This percentage will be used

again for 2022/23. Based on the 3rd quarter quantum reports from Welsh Health Legal Services this has resulted in a decrease in the provision of £1.077M (of which the Welsh Risk Pool Element is £0.977M). This figure may be subject to change as more recent quantum is received.

PTHB also account for claims against the previous Health Authorities, which were reorganised into Health Boards in April 2003. These claims are fully managed by the Welsh Risk Pool on behalf of the THB. This provision although material within the THB accounts is fully funded by Welsh Risk Pool. Therefore, any financial impact on movement of this provision year on year is reimbursed to the Health Board via the Welsh Risk Pool so has no impact on the reported position of the Teaching Health Board.

III. Accounting for Redress Provisions

At the end of the 2018/19 financial year responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool. At the same time, Welsh Risk Pool changed the accounting requirement for redress cases from a cash basis to an accruals basis therefore requiring provisions to be included in the 2018/19 accounts for redress cases for the first time. This accounting treatment is again in place for 2022/23 with provisions for redress cases being included in the accounts based on estimated claim costs provided locally by the Concerns Team. Therefore, as at month 10 a provision of £0.138M is anticipated for this scheme in the 2022/23 year-end accounts. This amount may be subject to change based on the receipt of March 2023 quantum's but is not expected to be significant. As all payments made in respect of redress cases except for the claimant's legal costs (capped at £1,920) are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

IV. GP Indemnity Scheme

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GPs and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. To date the health board has received five claims under this scheme with four remaining ongoing. Therefore, as at month 10 a provision of £0.024M is anticipated for this scheme in the 2022/23 year-end accounts. This amount may be subject to change based on the receipt of March 2023 quantum's but is not expected to be significant. As all payments made in respect of such cases are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

F. Other Matters

i) Revenue Covid

Covid-19 expenditure has been monitored and reported to WG throughout 2022/23 on four returns:

- Table B3 – covers all Covid Costs including local response costs, recovery costs, Test Trace & Protect (TTP) and Mass Vaccinations
- Test Trace & Protect (TTP) includes both Health and Local Authority Costs for the delivery of this programme.

- Mass Vaccinations – this includes the costs of the delivery of the Mass Vaccination programme for Covid-19. The vaccine costs have not incurred by the Health Board and so are not included in this return which focuses on costs for running the Health Board Vaccination Centres and the GMS Enhanced Service,
- Other C19 & Exceptional includes expected other C-19 response, Energy, National Insurance & Real Living Wage costs.

ii) Annual Leave

Historically the Health Board has required all staff to utilise annual leave in full and so no annual leave accrual has been included within the Annual Accounts. However, 2020/21 and 2021/22 were unprecedented years and it was recognised that staff across all disciplines may not have had the opportunity to take their full annual leave entitlement. Therefore, a provision was included within the 2020/21 and 2021/22 Annual Accounts.

The Executive Team communicated to the organisation that it was now reverting back to its policy and for all staff to utilise annual leave in full and so it is not anticipated that an annual leave accrual will be included within the Annual Accounts

iii) Expenditure linked to Covid

Covid forecast full year expenditure, including TTP and Mass Vaccinations at the end of Month 11 was estimated to be in region of £13.3m. The overall expenditure for Powys will include the mass vaccination programme, enhanced cleaning standards, extended flu, long covid, discharge support, facilities cost, increased bed & workforce due to impact of covid. For the note in the Annual Accounts the spend will impact on numerous areas of expenditure.

iv) Expenditure linked to National Pressures

National Pressures forecast full year expenditure, including additional energy, NI & real living wage at the end of Month 11 was estimated to be in region of £3.7m. For the note is the Annual Accounts the spend will impact on numerous areas of expenditure. To note the Energy costs will be based on the latest supplier forecast available at Month 12.

v) Commissioning Contracts (note NCA no change)

At the start of 2020/21 it was recognised that the previous LTA arrangements would not be adequate during the pandemic. So historically:

- English Contracts – through the year an agreed cash value is paid to each provider monthly. However, as the contract is in the main on a cost per case agreement using the English Tariffs rates, work is required to estimate the impact of actual performance in the Annual Accounts using the most up to date information available. The final settlement of this creditor / debtor will not be resolved until the summer once the full MDS data has been received and reviewed in detail by the Health Board.
- Welsh Contracts – paid in year at an agreed value based on historic activity and financial values uplifted by an All Wales %. At the end of the year contract performance is agreed using a marginal rate and finalised prior to the end of the financial year as part of the intra NHS Balance Agreement process.

For 2022/23, a new approach to contracting was agreed by the Finance Directors from the seven Health Boards, Velindre and WHSSC, whereby inpatient and day

case activity is being charged at a marginal rate for over and under performance with a tolerance built in for activity delivered between 90% – 100% of 2019/20 out turn. Outpatients have remained on a block payment basis.

Arrangements with NHS England were again led by Welsh Government for 2022/23 with contracts returning to a cost per case basis for all contracts under the £30M Aligned Payment Incentive scheme threshold.

vi) Continuing Health Care

The THB is expecting to continue holding amounts within its Statement of Financial Position in respect of two individual Continuing Health Care cases at a value of £1.790M (including estimated legal fees) regarding claims from Powys County Council that the Health Board is responsible for care provision fees in respect of the individual patients. These claims are being managed by NWSSP Legal and Risk and it is not envisaged that finalisation of these claims will take place prior to 31 March 2023, therefore, these amounts will continue to be held until the cases are concluded.

4. REMOTE WORKING

It is anticipated that the Audit Team will be working remotely for the period of the audit although this has not been formally communicated. The THB finance department continue to work closely with the Audit Wales Team to make arrangements for information flow and communication methods to facilitate this and it is not anticipated that this approach will be detrimental to the delivery of the Audit.

The THB and Audit Wales teams, as in previous years, will utilise the Inflow software for provision of working papers and responses to audit queries. The success of the use of this software in Powys has led to the rollout of this in other NHS Wales organisation audits for this financial year.

5. RECOMMENDATIONS

5.1. The Audit Committee is asked to note and approve:

a) The timetable, key dates and milestones for the submission of the Annual Accounts for 2022/23;
b) the arrangements in place for the review and adoption of the Annual Accounts;
c) the approach for accounting for capital issues;
d) the approach for accounting for primary care accruals;
e) the approach for accounting for retrospective continuing health care claims;
f) the anticipated movements in other key provisions;
g) the impact of other matters on the financial position.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 2.3

Audit, Risk and Assurance Committee	**Date of Meeting: 21 March 2023**
Subject:	**Annual Internal Audit Plan 2023/24**
Approved and Presented by:	Board Secretary / Head of Internal Audit
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To present the draft Internal Audit Plan for 2023/24 to the Committee for review, comment and approval.

To present the updated Internal Audit Charter to the Committee for review and approval.

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Approve** the Internal Audit plan for 2023/24.
- **Approve** the Internal Audit Charter as at March 2023.
- **Note** the associated Internal Audit resource requirements and Key Performance Indicators.

Approval	Discussion	Information
X	X	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The draft Internal Audit plan for 2023/24 has been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents.

Individual planning discussions were held with each of the Executive Directors, the Chief Executive, Chairman and ARAC Chair to inform development of the plan.

An initial version of the draft plan was shared with the Executive Committee for review and comment, and to inform prioritisation of the potential audits to ensure that the plan can be delivered within the available resources.

The plan covers the whole of the 2023/24 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

BACKGROUND AND ASSESSMENT:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Powys Teaching Health Board.

It is a requirement of the Public Sector Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be completed in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit Committee approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards.

The Internal Audit Charter has been updated as at March 2023 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

NEXT STEPS:

Progress towards delivery of the Internal Audit plan will be reported to each meeting of the Committee during 2023/24.

Annual Internal Audit Plan: Draft Internal Audit Charter

March 2023

Powys Teaching Health Board

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2023/24 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly, this document sets out the risk-based approach and the Plan for 2023/24. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP, Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

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

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) (Recovery and Sustainability Plan) and Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no/unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NWSSP, DHCW, WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

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

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP) (Recovery and Sustainability Plan);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Patient Experience, Quality and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executive Directors and Independent Members to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Health Board's Executive

Committee to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Corporate Risk Register.

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

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

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

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

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

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject

to change to ensure it remains fit for purpose.

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

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

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the health board will need to pay an additional £64,325 (£57,614 in 22/23) to cover this additional audit work.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. Noting the anticipated profile of activity within the Health Board during 2023/24, this additional charge is reduced from previous years to £14,367 (£24,150 in 22/23).

Therefore, the Health Board will be charged an additional amount of £78,692 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2023/24. Recharges may be adjusted to reflect annual NHS inflationary uplifts.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2023/24 and:

- approve the Internal Audit Plan for 2023/24;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit (Powys Teaching Health Board)
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2023/2024

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Risk Management & Assurance	1		Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	Director of Corporate Governance	Q4
Board & Committee Structure / Effectiveness	2		Evaluate the Health Board's Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	Director of Corporate Governance	Q2/3
Staff Recruitment & Retention	3	CRR 006	Review and assessment of the plans and processes in place to enable the Health Board to recruit and retain an appropriate workforce to allow the sustained delivery of high-quality services.	Director of Workforce & Organisational Development	Q3/4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			Include focus on the Health Board's approach and structures around retention.		
Clinical Education - HCSW induction scheme	4		Review of the design and deployment of the Framework for Health Care Support Workers. Include review of induction scheme to establish if effective processes are in place to ensure compliance with the requirements of the Framework.	Director of Workforce & Organisational Development	Q2
Quality & Safety Governance – Incident Management	5	CRR 003	Following on from the Incident Management audit completed in 2022/23. Focused review of processes for management of incidents and ensuring effective learning from events. To be undertaken within Maternity and a second comparator area to be agreed.	Director of Nursing & Midwifery	Q3
Infection Prevention and Control	6		Review of the structures, plans, monitoring and reporting arrangements in place across the Health Board (including Primary Care and Care Homes) to ensure that the	Director of Nursing & Midwifery	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			risk of infection is minimised, and the spread of infection is effectively controlled, and all relevant guidelines and legislation are complied with.		
Efficiency Framework / Value Board	7	CRR 001 & 002	Provide assurance around the development, monitoring and achievement of the Health Board's financial plans linked to efficiency and sustainability. Exact scope to be determined in year as the work around the accelerated sustainability model and Patient related outcome Measures / Patient Related Experience Measures progresses.	Director of Finance Information & IT Services	TBC
Variable Pay	8	CRR 001	Scope and focus of the audit to be agreed.	Director of Workforce & OD / Director of Finance Information & IT Services	TBC
Information Governance	9		Review the resourcing, capacity, and resilience of the Information Governance structures to achieve	Director of Finance	Q1

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			compliance with GDPR and FoI requirements.	Information & IT Services	
IT Infrastructure and Asset Management Follow-up	10		Follow-up of 22/23 Limited Assurance report. Will need to agree the timescale for carrying out the follow-up	Director of Finance Information & IT Services	TBC
Cyber Security Follow-up	11		Follow-up of 22/23 Limited Assurance report. Will need to agree the timescale for carrying out the follow-up	Director of Finance Information & IT Services	TBC
Clinical Audit	12		Review the adequacy of the systems and controls in place for the planning, delivery and reporting of Clinical Audit work.	Medical Director	Q1
Frailty / End of Life Care Services	13		A review of Frailty and / or Endo of Life Care Services to be included for the second half of the plan. Exact scope of the review will need to be considered and agreed.	Medical Director	Q3/4
Patient Experience	14	CRR 003	Review of the arrangements and processes in place around patient experience, potentially focusing on quadrant reporting.	Director of Therapies and Health Science / Director of	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			Joint Executive lead with Director of Nursing. Further discussion needed to determine and agree exact scope.	Nursing & Midwifery	
Additional Learning Needs Legislation	15	CRR 006	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	Director of Therapies and Health Science	Q2
Welsh Language Standards Follow-up	16		Follow-up of 22/23 Limited Assurance report. Will need to agree the timescale for carrying out the follow-up	Director of Therapies and Health Science	TBC
Continuing Healthcare (CHC)	17	CRR 001	Review the processes in place for the assessment, approval, recording and monitoring of CHC to ensure that care is provided to the required standards with appropriate financial controls in operation. Review to include the arrangements covering Child, Adult and Mental Health.	Director of Primary, Community & Mental Health /	Q2/3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Primary Care - Dental Services	18	CRR 008	Executive identified Dental Services as one of the key areas for review within Primary Care – Relating to access for patients. Further discussion with Assistant Director of Primary Care Services to determine exact scope.	Director of Primary, Community & Mental Health	Q2/3
Integrated Performance Framework	19	CRR 007	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned. Scope to include how the Health Board are managing quality from visiting clinicians and the interface with EASC / WHSSC.	Director of Planning & Performance	Q3/4
Partnership Governance Framework	20	CRR 007	Review of the development and implementation of the Framework.	Director of Planning & Performance / Director of Corporate Governance	Q4

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Vaccination Programmes	21	CRR 011	Review the development of structures and plans for the on-going delivery of vaccination programmes.	Director of Public Health	Q4
Business Continuity Planning	22	CRR 011	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Scope to include IT technical continuity and fault domain awareness within the organisation.	Director of Public Health	Q3/4
Health & Safety Arrangements	23		Review and assess the adequacy of the structures, governance arrangements, policies and processes in place within the Health Board to ensure compliance with Health & Safety legislation.	Director of Environment	Q3
Estates Assurance – Estates Condition	24	CRR 010	To determine the adequacy of, and operational compliance with, the health board's systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.	Director of Environment	TBC

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Follow – up Action Tracker	N/A	N/A	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Board Secretary	Q4
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A	CRR 010	In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the health board to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2023/24 plan to enable us to work with the health board to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.	Director of Environment	See IAAPs

Please note: The national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2023/24 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2022/23 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

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

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

- Board means the Board of Swansea Bay University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Swansea Bay University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

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

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

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

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

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

3 Independence and Objectivity

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

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

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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

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

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

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

4 Authority and Accountability

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

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

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

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

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Risk & Assurance Committee

also has regular private meetings with the Head of Internal Audit.

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

5 Relationships

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

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

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

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

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

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

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

5.8 The Audit Risk & Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Risk & Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

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

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

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

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

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

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

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

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

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

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

- the provision to the Accountable Officer and the Audit Risk & Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

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

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

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

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Risk & Assurance Committee on behalf of the Board.

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

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the

relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

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

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Risk & Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Risk & Assurance Committee requirements; and
- The Audit Risk & Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Risk & Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Risk & Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Risk & Assurance Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.

- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable

- Achievable
- Relevant / Realistic
- Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Risk & Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Risk & Assurance Committee.

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

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

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

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2023

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Powys Teaching Health Board

Outline Audit Plan 2023

Audit year: 2022-2023

Date issued: March 2023

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Our ambitions:

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend sharing a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends undertaking to address the audit risks identified and other key areas of audit focus during 2023.

Adrian Crompton
Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2023 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates and also highlights the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2023, following completion of my detailed risk assessment.

Jamieson,Liz
10/03/2023 15:10:13

Your engagement team:

Dave Thomas	**Engagement Director & Audit Director (Performance Audit)**
Derwyn Owen	**Audit Director (Financial Audit)**
Anne Beegan	**Audit Manager (Performance Audit)**
Mike Jones	**Audit Manager (Financial Audit)**
Alice King	**Audit Lead (Financial Audit)**
Bethan Hopkins	**Audit Lead (Performance Audit)**

We confirm that our audit team members are all independent of the Health Board and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February 2023	March 2023
2023 Detailed Audit Plan	February – April 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May - July 2023	July 2023
Performance audit work: • Structured Assessment, incorporating a deep dive into a specific thematic area which will be confirmed in the detailed plan in May 2023. • All-Wales thematic review of planned care, following on from my previous work in this area in 2022. • Local project work (to be confirmed in detailed plan in May 2023)	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

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Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of ICAEW

Appendix 1 – the key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes.

Key change	Potential impact on your organisation
	Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

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To:
NHS Audit Committee Chairs
NHS Directors of Finance
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Reference: AC350/3415A2023

Date issued: 1 March 2023

Dear colleague

NHS – Audit of Accounts 2022-23

We are about to commence our accounts audit work for all NHS bodies in Wales and I am conscious that the closure of the 2022-23 NHS financial statements will be challenging to both Audit Wales and the NHS.

In the attached letter, my Executive Director of Audit Services provides some important information on the introduction of a new auditing standard. The new standard fundamentally impacts how we will undertake the 2022-23 audit and has implications for you and your teams. The letter gives more detail on the standard itself and its impact on fees and the 2022-23 audit certification deadline.

I am acutely conscious that the message is a difficult one, with our fee rates increasing and deadlines moving later, at a time when colleagues everywhere in the public service are under great pressure. It is for that reason that I wanted to write to you directly, to explain the drivers behind the changes and to give my assurance that Audit Wales will be doing all it can, in the coming years, to continue to provide high quality audit, delivered efficiently, and that we have a plan to bring deadlines forward. I would like to thank you for your continued communication and engagement, which are so vital if we are to deliver those things.

In respect of the certification deadlines, the introduction of the revised Standard, and a radically different audit approach, has implications for audit timetables and it is inevitable that the new approach will require additional time to implement. I am also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

Given the circumstances set out above, I feel I have no option but to extend the audit certification deadline to 31 July 2023 to ensure I build in sufficient time to deliver an audit that meets my high standard in terms of audit quality.

That said, it is essential I recover this position in future years. In terms of my proposed certification deadlines in 2023-24 and 2024-25, I have signalled to my colleagues at Audit Wales the importance of recovering the position and a continual and collaborative dialogue with NHS colleagues is crucial.

To help us achieve the proposed certification deadlines set out in the attached letter, my Engagement Director and audit teams will continue to liaise closely with you and your colleagues. Notwithstanding the ongoing dialogue taking place at a local level, I have asked my Executive Director of Audit Services to arrange discussions with key stakeholder groups across the NHS. I hope that this is a helpful update and I wish you all the very best for the forthcoming audit of accounts.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

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[by-email]

Reference: 3415A2023

Date issued: 1 March 2023

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2022-23

1 We are about to commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on the introduction of a revised auditing standard which fundamentally impacts on how we will undertake your 2022-23 audit.

2 Within this letter we consider:

- the impact of the revised standard;
- the resultant impact on audit fees; and
- the timetable for the Audit of Accounts 2022-23 and for future years.

The impact of ISA 315

3 Our audits of NHS accounts for the year ended 31 March 2023 will be carried out under a revised auditing standard (ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020)).

4 This revised standard is effective for audits of accounts for periods beginning on or after 15 December 2021 and applies to the audit of all private and public sector entities across the UK, regardless of their nature, size or complexity.

5 The revised standard will have significant and far-reaching impacts on how auditors undertake audit risk assessments and our overall audit approach.

6 In planning our audit, we will be required to undertake more detailed and extensive risk assessment procedures to identify risks of material misstatement. The subsequent design and performance of our audit approaches will be responsive to each assessed risk.

7 **Appendix 1** outlines the key changes and the potential impact on your organisation in terms of information requests from our audit teams.

8 The standard has been amended to drive better quality, more effective risk assessments, as well as to promote greater exercise of professional scepticism. It also requires us to obtain a much more robust understanding of an organisation's IT systems. Financial reporting frameworks and governance structures are becoming increasingly complex, while technology continues to play a more advanced role in the control environment of entities. These changes require risk identification and assessment to be enhanced and rigorous audit processes.

9 The previous standard did not address automated tools and techniques, which are increasingly being used by auditors to inform risk assessment. All audits of 2021-22 NHS accounts incorporated elements of our Analytics Assisted Audit. The revised standard introduces specific considerations relating to the auditors' use of automated tools and techniques.

Impact on audit fees

10 As a result of the changes outlined above, we expect 2022-23 audits to take longer to complete. We will also be required to use more experienced CCAB qualified staff on audits to deal with the higher level of judgement necessitated by the standard.

11 In our August 2022 Consultation on Fee Scales, we indicated that our initial assessment of the impact of this richer skill mix on fees was a potential average increase in fee scales for our financial audit work of between 12% and 18%. This is consistent with expectations in other UK public audit bodies and the private sector audit firms.

12 We have now started more detailed risk assessment under the new audit approach and will be able to provide you with an updated assessment of the audit fee once we have completed that initial risk planning. Our initial estimate is

that audit fees will increase by 10.2% for ISA 315, in addition to the 4.8% inflationary increase set out in our Audit Wales 2023-24 Fee Scheme . Your Engagement Director will discuss the proposed fee for your audit once that risk assessment has been completed.

Timetable for the Audit of Accounts 2022-23

13 The introduction of the revised Standard and a radically different audit approach has implications for audit timetables. We have worked closely with the other UK Public Audit Bodies to develop an audit methodology which, we believe, will add value to Audited Bodies whilst continuing to maintain the high-quality audit which we know you expect from us. However, it is inevitable that the new approach will require additional time to implement.

14 We are also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

15 We will be working closely with NHS finance teams over the next few weeks to agree the precise timings for submission of NHS draft accounts. There will also be logistical matters to consider, such as managing staff annual leave and potentially securing revised Audit Committee, Board and Annual General Meeting (AGM) dates. We are aware that Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

16 From our discussions with Health Bodies, we are aware that a number of you are struggling to recruit experienced finance staff and that this may also impact audit timetables. We are facing similar challenges and know that this position is consistent with the National Audit Office (NAO), Audit Scotland and the Northern Ireland Audit Office. The NAO's recovery plan article is a useful reference in this context[1]. In addition, a more recent report by the National Audit

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[1] The NAO: getting government accounts back on track | ICAEW

[2] Timeliness of local auditor reporting on local government in England

Office (January 2023) highlights how the delays to local government audit opinions are impacting elsewhere in the public sector, including the NHS, and describes plans to get back on track with the timetable for published audit opinions[2].

17 For information, reporting deadlines in England are slightly more complicated, with providers and commissioners having different dates and different requirements around annual reports. The NAO have just published in their opinion for the Department of Health and Social Care Annual Report and Accounts 2021-22 (page 264) that 25% of providers in NHS England and 20% of commissioners failed to meet the Department of Health and Social Care audited accounts deadline in 2021-22.

18 As the auditors of Local Government Bodies in Wales, we have been experiencing similar delays to those seen in England in completing our audit of the 21-22 accounts. These delays result mainly from a technical issue regarding the valuation of Local Government infrastructure assets, which resulted in the Welsh Government deferring the audit certification deadline to 31 January 2023 and have impacted our ability to commence our 2022-23 audits in line with previous year timetables.

19 Taking all of this into account and having discussed with colleagues in Welsh Government responsible for preparing the NHS Consolidated accounts, we are therefore proposing an audit certification deadline of **31 July 2023** for NHS Bodies in Wales.

20 We recognise that this is later than many bodies would like but we believe it is important to set realistic timescales we can all work to. Over the next three years our plan would be to revert to a 15 June deadline as follows:

- Audit of Accounts 2022-23 – certification by 31 July 2023;
- Audit of Accounts 2023-24 – certification by 30 June 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

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21 You will note that by 2024-25, we are not intending to revert to the pre-covid 31 May deadline but will aim to certify accounts by 15 June. This will ensure that the time required for Health Boards and Trusts to circulate the requisite accounts and audit reports to the Audit Committee and the Board, does not compress the audit window to less than a month.

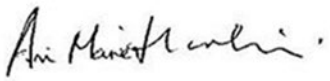
22 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

23 We value the constructive working relationship we have with your finance teams and will continue to work closely with you to bring forward the deadlines for future years.

24 We remain committed to working collaboratively with you to successfully navigate this challenge, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – the key changes to the standard and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.1

Audit, Risk and Assurance Committee	**Date of Meeting: 21st March 2023**
Subject:	**Internal Audit Progress Report**
Approved and Presented by:	Board Secretary / Head of Internal Audit
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee and proposed amendments to the 2022/23 plan.

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Note** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
- **Approve** the removal of the highlighted audit from the 2022/23 plan.

Approval	Discussion	Information
X		X

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The progress report highlights the conclusions and assurance ratings for audits finalised in the current period.

The following three audit reports have been finalised since the January 23 meeting of the Committee:

- Therapies and Health Sciences Professional Governance Structure (Reasonable Assurance)
- Incident Management (Reasonable Assurance)
- Cyber Security (Limited Assurance)

The progress report also includes details of the proposed removal of one audit from the 2022/23 plan.

BACKGROUND AND ASSESSMENT:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to Powys Teaching Health Board.

The work undertaken by Internal Audit is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the engagement process established with the Health Board.

The 2022/23 plan was formally approved by the Audit, Risk and Assurance Committee at its March 22 meeting.

The progress report provides the committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee and proposed amendments to the plan.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including commentary as to progress with the delivery of assignments.

NEXT STEPS:

A progress report will be submitted to each meeting of the the Audit, Risk and Assurance Committee.

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
March 2023

NWSSP Audit and Assurance Services

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
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Powys Teaching Health Board

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2022/23 Internal Audit plan.

The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

The plan for 2022/23 was agreed by the Audit, Risk & Assurance Committee in April 2022 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Outcomes from Completed Audit Reviews

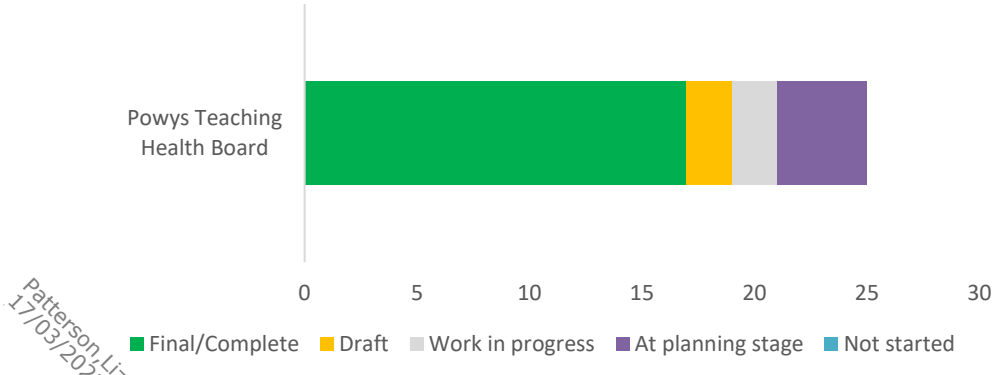
Three assignments from the 2022/23 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The full versions of the reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Therapies and Health Sciences Professional Governance Structure	Reasonable	
Incident Management		
Cyber Security	Limited	

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 25 reviews included within the 2022/23 Internal Audit Plan (excluding the removed audit detailed under section 4 below), and overall progress at this stage of the year is summarised below.



From the illustration above it can be seen that seventeen audits have been finalised so far this year.

In addition, there are two audits that are at the draft report stage, two that are currently work in progress and a further four at the planning stage.

Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators.

4. Changes to the 2022/23 Plan

Proposed removal of Covid 19 – Outbreak Control Plan, Contact Tracing audit

Following discussions with the Director of Public Health it has been identified that the planned audit should be removed from the 2022/23 plan as it is no longer appropriate due to the changing Covid 19 situation.

5. Engagement

During the current reporting period, the Audit & Assurance team have observed Board and Sub Committees and held meetings as follows:

Board / Sub Committees

- Management Executive – 8 March

Health Board Meetings

- Helen Bushell, Director of Corporate Governance – 2, 28 February & 9 March
- Carl Cooper, Chairman – 8 February
- Carol Shilabeer, Chief Executive – 16 February
- Mark Taylor, ARAC Chair – 24 February
- Audit Wales / HiW / Ombudsman – 28 February

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	PInd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Site Leadership and Coordination (Deferred from 21/22)		24	Environment	2		Final	Advisory	September
IT Infrastructure and Asset Management		9	Finance, Information & IT	1		Final	Limited	September
Control of Contractors: Follow-up		*25*	*Environment*	*1*		*Final*	*Substantial*	*November*
Decarbonisation		*22*	*Environment*	*2*		*Final*	*Advisory*	*November*
Staff Rostering		02	Workforce & OD	~~3~~	2	Final	Reasonable	November
Security Services		20	Environment	1		Final	Reasonable	November
Machynlleth Hospital Reconfiguration Project		*21*	*Environment*	*3*		*Final*	*Reasonable*	*January*
Looked After Children Health Assessments (Deferred from 21/22)		5	Nursing & Midwifery	2		Final	Substantial	January
Cancer Services - Access to Symptomatic FIT (Deferred from 21/22)		11	Medical	2		Final	Substantial	January
Welsh Language Standards		13	Therapies & Health Science	1		Final	Limited	January
North Powys Wellbeing Programme (Deferred from 21/22)		16	PC&MH	~~1~~	2	Final	Reasonable	January
Charitable Funds		8	Finance, Information & IT	2		Final	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Workforce Futures Strategic Framework (Deferred from 21/22)		4	Workforce & OD	3		Final	Reasonable	January
Women & Children's Services		18	PC&MH	~~1~~	2	Final	Substantial	January
Therapies and Health Sciences Professional Governance Structure		14	Therapies & Health Science	~~4~~	3	Final		March
Incident Management		6	Nursing & Midwifery	3		Final		March
Cyber Security		10	Finance, Information & IT	3		Final		March
Temporary Staffing Department	Review of systems and controls covering requesting, authorising & paying of bank & agency staff	3	Workforce & OD	~~1~~	3	Draft	Reasonable	May
Performance Management & Reporting (Deferred from 21/22)	Effectiveness of the Health Board's performance management and reporting arrangements, ensuring the achievement of an Integrated approach through the Improving Performance Framework.	15	Planning & Performance	3		Draft	Substantial	May
Savings Plans / Efficiency Framework	Development, monitoring and achievement of the Health Board's savings plans linked to recovery and the associated Efficiency Framework.	7	Finance, Information & IT	4		Work in Progress		May
Board Assurance Framework / Risk Management	Focus on development of effective assurance processes alongside risk identification / escalation.	1	Board Secretary	4		Work in Progress		May
Follow-up Action Tracker	Review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	23	Board Secretary	4		Planning		May
SLAs for In-reach Medical Staff	Actions taken to review and update SLA arrangements for in-reach medical staff across all Health Board services.	12	Medical	4		Planning		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Occupational Health Follow-up	Follow-up of 21/22 Limited Assurance report to establish progress with implementation of agreed actions.	26	Workforce & OD	4		Planning		May
Planned Care / Recovery of backlog Services	Provide assurance across key areas - Community Services / planned care / recovery of backlog services	17	Planning & Performance	3		Planning		June
Reviews removed from the plan								
Covid 19 – Outbreak Control Plan, Contact Tracing	Use of WG contact tracing funding to allow health Staff to respond to Covid outbreaks.	25	Proposed for removal as no longer appropriate due to the changing Covid 19 situation. To be agreed by March 23 ARAC					

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G Rating
Site Leadership and Coordination	Advisory	Final	18/08/22	09/09/22	25/08/22	25/08/22	G
IT Infrastructure and Asset Management	Limited	Final	25/08/22	16/09/22	13/09/22	14/09/22	G
Control of Contractors: Follow Up	*Substantial*	*Final*	*12/09/22*	*04/10/22*	*22/09/22*	*22/09/22*	*G*
Decarbonisation	*Advisory*	*Final*	*30/09/22*	*24/10/22*	*13/10/22*	*20/10/22*	*G*
Staff Rostering	Reasonable	Final	11/10/22	02/11/22	20/10/22	21/10/22	G
Security Services	Reasonable	Final	25/10/22	16/11/22	09/11/22	09/11/22	G
Machynlleth Hospital Reconfiguration Project	*Reasonable*	*Final*	*18/11/22*	*09/12/22*	*02/12/22*	*02/12/22*	*G*
Looked After Children Health Assessments	Substantial	Final	06/12/22	29/12/22	06/12/22	06/12/22	G
Cancer Services – Access to Symptomatic FIT	Substantial	Final	29/11/22	20/12/22	8/12/22	8/12/22	G
Welsh Language Standards	Limited	Final	21/10/22	11/11/22	12/12/22	16/12/22	R
North Powys Wellbeing Programme	Reasonable	Final	01/11/22	22/11/22	15/12/22	16/12/22	R
Charitable Funds	Reasonable	Final	29/11/22	20/12/22	20/12/22	20/12/22	G
Workforce Futures Strategic Framework	Reasonable	Final	06/12/22	29/12/22	17/01/23	18/01/23	R
Women and Children's Services	Substantial	Final	13/01/23	03/02/23	19/01/23	19/01/23	G
Therapies and Health Sciences Professional Governance Structure	Reasonable	Final	02/03/23	23/03/23	08/03/23	08/03/23	G
Incident Management	Reasonable	Final	23/02/23	16/03/23	07/03/23	09/03/23	G
Cyber Security	Limited	Final	08/02/23	03/03/23	03/03/23	09/03/23	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	March 2022	By 30 June	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 19 from 19	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	82% 14 from 17	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 17 from 17	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Therapies and Health Sciences Professional Governance Structure

Final Internal Audit Report

February 2023

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Powys Teaching Health Board

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Review reference:	PTHB-2223-14
Report status:	Final
Fieldwork commencement:	23rd January 2023
Fieldwork completion:	27th February 2023
Debrief meeting:	8th March 2023
Draft report issued:	2nd & 8th March 2023
Management response received:	8th March 2023
Final report issued:	8th March 2023
Auditors:	Ian Virgill, Stuart Bodman
Executive sign-off:	Claire Madsen, Executive Director of Therapies & Health Science
Distribution:	Lucie Cornish, Assistant Director of Therapies & Health Science Victoria Deakins, Head of Therapies and Professional Head of Occupational Therapy Aled Falvey, Professional Head of Physiotherapy Michelle Kirkham, Professional Head of Radiography Peter Taylor, Professional Head of Podiatry
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The overall objective of the audit was to review the controls and processes in place in respect of the implementation of the Therapies and Health Sciences Professional Governance Structure.

Overview

We have issued reasonable assurance on this area.

The Therapies and Health Sciences Directorate has structures in place within the areas sampled which allows for scientific and therapy staff, professionsl registrants and practitioners to work within clearly defined professional and clinical governance arrangements.

The matters requiring management attention include:

- The need to review and finalise Health Board Policies and procedures relevant to Professional Governance and the 'All Wales Professional Accountability and Use of Professional Title Guidance'.
- The absence of an overarching Health Board Therapies and Health Sciences Professional and Clinical Governance Framework.
- Strengthening the process for identification of any professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	Policies and Procedures	Reasonable
2	Professional and Clinical Governance Frameworks	Reasonable
3	Identification of professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service.	Reasonable
4	Professional Heads of Service ensure that professionally registered staff are able and enabled to meet their respective professional standards.	Substantial
5	Professional registration status of Therapy and Scientific professionals is accurately maintained on ESR.	Substantial
6	Reporting lines and processes are in place to allow for timely escalation and remedy of issues arising from non-compliance of professional governance standards to the DoTHS.	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Policies and Procedures to effectively support implementation of the Guidance.	1	Design	Medium
2	Absence of Health Board Therapy and Health Sciences Professional and Clinical Governance Framework.	2	Design	Medium
3	Formal identification of professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service.	3	Design	Medium

1. Introduction

1.1 Our review of the 'Therapies and Health Sciences Professional Governance Structure' was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The role of the Executive Director of Therapies and Health Sciences (DoTHS) holds responsibility and accountability for all therapy and health science professionals, together with associated staff groups including those regulated by the Health and Care Professions Council (HCPC), those on non-statutory registers and support workers. The role includes providing assurance to the Health Board that therapy and scientific registrants and practitioners work within a clearly defined professional and clinical governance framework, incorporating the 7 pillars of Clinical Governance. Within the Health Board this role is discharged via the Professional Heads of Service.

1.3 With transformation of health services there has been an increase in the development of non-profession specific job roles where the person specification requires a registrant but identifies that a post-holder could be from a variety of professional backgrounds. There are instances of those professions within the DoTHS' responsibility holding such posts, and there may be no defined line of professional accountability to the DoTHS.

1.4 An All-Wales Guidance document entitled 'Professional Accountability and Use of Professional Title in the Therapy and Health Science Professions' (the "Guidance") was produced in July 2022. The purpose of the document was to provide guidance on the minimum processes required to provide organisations, through the DoTHS, with the necessary assurance regarding the professional accountability of those professions within their responsibility. It was intended that the Health Board should establish local principles and policy to support implementation of the Guidance.

1.5 Our testing relating to the establishment of professional and clinical governance frameworks across the Therapies and Health Sciences Directorate and implementation of the Guidance was undertaken within the Radiography, Physiotherapy, Occupational Therapy and Podiatry Departments.

1.6 The risks associated with our review are as follows:

- All Wales Guidance may not be implemented due to absence of a formal governance framework, reporting arrangements and supporting procedures at departmental level.
- Absence of oversight of registered therapy and health science professionals who are not directly operationally managed.
- Professional registration and standards are not kept up to date in accordance with statutory requirements leading to potential patient safety issues and / or staff being temporarily unable to work.

1.7 The Lead Executive for this review is the Executive Director of Therapies and Health Sciences.

2. Detailed Audit Findings

Objective 1: The Health Board has developed local policies and procedures to effectively support implementation of the Guidance, and these are readily available to relevant staff.

2.1 The Health Board has a number of local policies and procedures in place that are relevant to professional governance, including a Professional Registration Policy and Clinical Supervision Standard Operating Procedure. However, these are currently under review and require finalisation. Once finalised, the relevant policies and procedures will need to be linked into the overarching Framework referenced in paragraph 2.7 below (*Matter Arising 1 – Medium Priority*).

2.2 All four Professional Heads of Service (Radiography, Physiotherapy, Occupational Therapy, Podiatry) confirmed to the Auditor that they have received copies of the 'Guidance', and that it has been disseminated to their professionally registered staff, and they are conversant with its content.

Conclusion:

2.3 The Health Board has relevant policies in place, but they need to be reviewed and finalised, and then referenced within an overarching Professional and Clinical Governance Framework. We have provided reasonable assurance against this objective.

Objective 2: The Health Board has in place a clearly defined professional and clinical governance framework covering all professions regulated by the HCPC, that includes a forum to oversee, advise and coordinate appropriate application of professional accountability and use of professional title for Health Board Therapy and Health Science professionals.

2.4 Each of the four sampled departments of Radiography, Physiotherapy, Occupational Therapy and Podiatry has a current and documented professional and clinical governance framework in place that states clear professional structures and accountability arrangements. Each framework also provides direction to service managers with regards to recruitment, training to meet the requirements of the relevant Health and Care Professional Standards (HCPC) Standards of Proficiency and implementation of the 'Guidance'.

2.5 Our testing identified that each of the four departments have a Team Meeting/Forum in place that meets regularly to facilitate the facets of their respective clinical governance frameworks and allows for discussion of professional training and registration matters, and that these meetings are formally minuted.

2.6 When appropriate, progress outcomes or issues arising from their respective Professional Governance Frameworks are reported via the quarterly Professional Leads meetings chaired by the DoTHS.

2.7 Currently the Health Board does not have a formalised and overarching Professional and Clinical Governance Framework which provides central oversight, relationships, coordination and appropriate application of professional

accountability and use of professional title for professionally registered Therapy and Health Science staff *(Matter Arising 2 – Medium Priority).*

Conclusion:

2.8 Whilst formally constituted professional and clinical governance frameworks are in place within all four sampled departments, these need to be supported by and feed into a central Therapies and Health Sciences Professional and Clinical Governance Framework which will provide appropriate oversight and control. We have provided reasonable assurance against this objective.

Objective 3: Appropriate and periodic review or monitoring is undertaken to identify professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service.

2.9 The Professional Heads of Service for Physiotherapy and Occupational Therapy have in place a process and repository to identify and record registered professionals who are not operationally managed by them but are line managed elsewhere within the Health Board, to offer potential professional networking and CPD support opportunities.

2.10 The respective Professional Heads of Service for Radiography and Podiatry are confident that there are no registered professionals in their respective fields working elsewhere within the Health Board, given their profession's specialisations and clinical skillsets which would be non-transferable to a wider employ.

2.11 At the time of our audit there is no formal system in place as part of the enrolment process that identifies these staff types upon commencement of employment, and which advises a respective Professional Head of Service accordingly *(Matter Arising 3 – Medium Priority).*

2.12 Our testing identified that all sampled professionally registered staff Job Descriptions and Job Role Profiles relating to each of the four Departments, stated the Professional Title and the reporting line to a respective Professional Head of Service.

Conclusion:

2.13 Whilst processes are in place within the two aforementioned departments that identify, document and monitor registered professionals who are not managerially responsible to them, work should be undertaken to liaise with the Workforce & OD Team to enable capture of these staff at the point of enrolment with the Health Board. We have provided reasonable assurance against this objective.

Objective 4: Professional Heads of Service ensure that registered staff are able and enabled to meet their respective professional standards.

2.14 CPD and training requirements for their professionally registered staff members is discussed as part of the annual PADR process undertaken by Professional Heads of Service.

2.15 Our testing identified that all sampled professionally registered staff within each of the four Departments held PADRs that included training/CPD to assist in the maintenance of their professional registration status.

2.16 Additionally, testing was also undertaken within several Departments that employ staff who have been identified as being professionally registered but work to line managers elsewhere in the Health Board; namely, Paediatric Physiotherapy - Women and Children's Directorate; South Powys Mental Health Primary Care Service, Bronllys Hospital; North Powys Older Persons Mental Health Team and the Integrated Autism Service.

2.17 However, PADR evidence could only be obtained from three of these four areas confirming that their professionally registered staff who are not line managed by a Professional Head of Service aligned to their registered profession also held PADRs that discussed training/CPD to assist in the maintenance of their professional registration status (*Matter Arising 4 – Low Priority*).

Conclusion:

2.18 The majority of testing undertaken in areas with professionally registered staff not reporting to a Professional Head of Service confirmed that they held PADRs that enabled them to maintain their HCPC registration status. We have provided substantial assurance against this objective.

Objective 5: Records are maintained of all Therapy and Scientific registrants and practitioners working within the Health Board and their registration status is accurately maintained on ESR.

2.19 The Workforce and OD ESR Team ensure that the professional registration status of Therapy and Scientific registrants and practitioners working within the Health Board is recorded on ESR via an interface download from the HCPC database.

2.20 Professionally registered staff are sent an alert from ESR three months prior to the expiration date advising them that their registration is due to expire.

2.21 Each of the four Professional Heads of Service reviews the HCPC register toward the closing date of re-registration to ensure that staff have re-registered, and each also checks their staff ESR accounts to ensure that the membership recorded is current.

2.22 Our testing of a sample of professionally registered Therapy and Scientific professionals in each of the four departments identified that their registration status is accurately recorded as being current on ESR.

Conclusion:

2.23 The Health Board and the Professional Heads of Service have processes in place to ensure that Therapy and Scientific professional registration status is accurately maintained and recorded on ESR. We have provided substantial assurance against this objective.

Objective 6: Reporting lines and processes are in place to allow for timely escalation and remedy of issues arising from non-compliance of professional governance standards to the DoTHS.

2.24 All four sampled departmental Professional Heads maintain formal and regular reporting lines to the DoTHS via their quarterly Professional Leads meetings, whereby any cross-departmental professional governance issues would be discussed and any 'lessons learned' outcomes would be supported by appropriate action plans.

2.25 In the event of timely escalation and resolution of issues arising from non-compliance of professional governance standards, these would be undertaken on a one-to-one basis between the Professional Lead and the DoTHS.

2.26 None of the four sampled Professional Heads outlined any issues that required timely escalation and resolution arising from non-compliance of professional governance standards.

Conclusion:

2.27 Reporting lines and processes are in place to the DoTHS that enable timely escalation and remedy of issues in the event of non-compliance of professional governance standards. We have provided substantial assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies and Procedures to effectively support implementation of the Guidance. (Design)			**Impact**
We acknowledge that the Health Board currently has draft policies and procedures in place relating to Professional Registration and Clinical Supervision. However, these need to be reviewed, updated and finalised to ensure their relevance to the requirements of the Guidance. The policies will then also need to be linked into the overarching Professional and Clinical Governance Framework referenced in Matter Arising 2 below.			All Wales Guidance may not be implemented due to absence of a formal governance framework, reporting arrangements and supporting procedures at departmental level.
Recommendations			**Priority**
1.1	Review and finalise current policies and procedures and ensure they are referenced within the Professional and Clinical Governance Framework.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.2	The organisation Professional Registration policy review is to be finalised	31st July 2023	Lucie Cornish, ADOTH
	The organisation Clinical Supervision procedure review is to be finalised	31st July 2023	Vic Deakins, Head of Therapies
	Both documents to be referenced in the overarching framework document referenced in Matter Arising 2.	31st Oct 2023	Lucie Cornish, ADOTH

Matter Arising 2: Absence of Health Board Therapy and Health Sciences Professional and Clinical Governance Framework. (Design)	**Impact**
Each of the four sampled departments of Radiography, Physiotherapy, Occupational Therapy and Podiatry has a current, documented professional and clinical governance framework which is supported by meetings that enabled discussion and delivery of their respective frameworks. However, the Health Board does not currently have a formalised and overarching Professional and Clinical Governance Framework which provides central oversight, relationships, coordination and appropriate application of professional accountability and use of professional title for professionally registered Therapy and Health Science staff. It is acknowledged that at the time of our review work is currently underway towards the introduction of such a framework.	All Wales Guidance may not be implemented due to absence of a formal governance framework, reporting arrangements and supporting procedures at departmental level.

Recommendations		**Priority**
2.1	The Health Board should implement a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions regulated by the HCPC and other professional bodies. The structure should also include a forum that oversees, advises and coordinates appropriate application of professional accountability and use of professional title for Health Board Therapy and Health Science professionals which are currently in place within the four departments sampled.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.2	Implementation of a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions.	31st Oct 2023	Lucie Cornish, ADOTH

Matter Arising 3: Formal identification of professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service. (Design)	**Impact**
The Physiotherapy and Occupational Therapy Professional Heads of Service both have active approaches to identifying, recording and monitoring those registered professionals who are not operationally managed by them but are line managed elsewhere within the Health Board. Both Professional Heads of Service maintain Excel databases that enable them to capture these staff, and record where they work within the organisation and to contact them accordingly to offer networking and CPD support opportunities The compilation of their databases is based largely on ESR information provided by the WOD Team or via 'word of mouth' information, and the identification of these staff can be some time after they commence employment into their roles. However, there is currently no formal system in place within the staff induction process that identifies these staff at the time of their commencement of employment, and which advises Professional Heads of Service accordingly to make them aware of registered professionals for they are not managerially responsible.	Absence of oversight of professionally registered therapy and health science professionals who are not directly operationally managed.

It should be noted and acknowledged that the Professional Heads of Service for Radiology and Podiatry are confident that there are no registered professionals in their respective fields working elsewhere within the Health Board given their profession's specialisations and focussed skillsets which are deemed as non-transferrable.		
Recommendations		**Priority**
3.1	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.2	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	31st Oct 2023	Lucie Cornish, ADOTH

Matter Arising 4: Training and CPD support to maintain registration for professional staff not managed by Professional Heads of Service. (Operation)	**Impact**
Each Professional Head of Service confirmed that CPD and training requirements for their professional staff members is undertaken as part of the annual PADR process. Our testing identified that all sampled professionally registered staff within the Physiotherapy, Occupational Therapy, Radiography and Podiatry Departments held current PADR forms that included discussion on training/CPD to assist in the maintenance of their professional registration status. We also undertook the same testing within several Departments that employ staff who have been identified as being HCPC registered staff but work to line managers elsewhere within the Health Board; namely, Paediatric Physiotherapy - Women and Children's Directorate; South Powys Mental Health Primary Care Service, Bronllys Hospital; North Powys Older Persons Mental Health Team and the Integrated Autism Service. Whilst PADR documentation was obtained from three of the four areas confirming that the sampled professionally registered staff discussed training/CPD to assist in the maintenance of their professional registration status, no PADRs could be obtained from the North Powys Older Persons Mental Health Team despite several requests submitted to the relevant line manager. Patterson,Liz 17/03/2023 15:10:13	Potential risk of Professional registration and standards are not kept up to date in accordance with statutory requirements leading to potential patient safety issues and / or staff being temporarily unable to work.

Recommendations			Priority
4.1	Management should ensure that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.2	Professional Heads of Service to provide assurance that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	31st Oct 2023	Professional Heads of Service

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
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Incident Management

Final Internal Audit Report

March 2023

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

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Report status:	Final Report
Fieldwork commencement:	07 December 2022
Fieldwork completion:	17 February 2023
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Draft report issued:	23 February 2023
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Final report issued:	09 March 2023
Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Ian Virgill, Head of Internal Audit
Executive sign-off:	Claire Roche, Executive Director of Nursing and Midwifery
Distribution:	Zoe Ashman, Assistant Director of Quality & Safety Elaine Scott, Lead Clinician - Quality & Safety
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The overall objective of the audit was to review the arrangements in place within the Health Board for the identification, recording, investigation and management of incidents.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Publishing a Health Board wide Incident Reporting procedural guidance and a navigable incident reporting page on SharePoint.
- Key stages / processes within the incident reporting cycle falling behind expected timelines.
- Lack of evidence of periodic reporting / monitoring of incidents within the Community Services Group.
- Lessons learnt from incidents not being monitored to ensure they are actioned.

A further recommendation / advisory point is within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Incident management policies and procedures.	Reasonable
2	Identification, recording and investigation of Incidents.	Limited
3	Reporting, monitoring and review of Incidents.	Reasonable
4	Actions taken and lessons learned.	Reasonable
5	Nationally Reportable Incidents.	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Outcome from CSG's Incident Reporting Review	*2*	Operation	High
2	Requirement of a Health Board Local Guide Procedure	*1*	Design	Medium
3	Accessibility of Incident Management Resources on SharePoint	*1*	Operation	Medium
4	Incidence Reporting and Governance Arrangement	*3&4*	Operation	Medium

1. Introduction

1.1 The review of 'Incident Management' was completed in line with the Powys Teaching Health Board's (the 'Health Board') 2022/23 Internal Audit Plan.

1.2 This review was originally highlighted in the plan as 'Directorate Quality & Safety Governance Arrangements'. However, it was agreed, in discussion with the Executive Director of Nursing and Midwifery, that a focused review be undertaken on a specific element of Quality and Safety each year, beginning with Incident Management.

1.3 All NHS organisations are accountable for the quality and safety of care provided to their respective populations. They must report all incidents of patient harm and near misses locally through their local risk management systems. This includes incidents across the whole patient pathway. They should be investigated appropriately and proportionately with actions taken accordingly, in line with Putting Things Right (PTR) requirements.

1.4 The Health Board is subject to the Duties within the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Duty of Candour focusses on the need to be open with patients, families and carers when things go wrong, building on the requirements already set out in PTR.

1.5 The Health Board's Serious Incident Policy Reporting, Investigating and Assurance Processes (PEP 004) underlines the procedures essential for the management of serious incidents in line with the Regulations as it applies to staff who have a responsibility to report and manage these serious incidents. "This policy sets out clear guidance on the management of serious incidents from the point of notification to closure of the related investigation, ensuring lessons have been learnt and shared, and assurance provided".[1]

1.6 The Executive Director of Nursing and Midwifery is the Executive lead for this review.

1.7 The potential risks are:

- Non-compliance with relevant legislation;
- Patient harm or poor patient experience;
- Financial loss; and
- Reputational damage with decreased public confidence.

[1] Policies & Written Control Documents - PEP 004 Serious Incident Policy Reporting, Investigating and Assurance Processes.pdf - All Documents (sharepoint.com)

2. Detailed Audit Findings

Objective 1: The Health Board has incident management policies and procedures in place that are up to date and have been communicated to all staff and are readily available

2.1 National incident reporting in NHS Wales changed from 14 June 2021 with the publishing of Phase 1 of the National Patient Safety Incident Reporting Policy by the Welsh Government.

2.2 The NHS Wales National Incident Reporting Policy Implementation Guidance Document (Phase 1) was coordinated and produced by the NHS Wales Delivery Unit for use by all NHS Wales Organisations, supporting how NHS Wales responsible bodies will implement the Welsh Government's National Incident Reporting Policy. Phase 2 which is yet to be published, will focus on new ways of national reporting, including thematic reporting of healthcare incidents.

2.3 The Health Board's SharePoint site has a Quality and safety section which includes Health Board, Welsh Government and the Delivery Unit's policy, guidance documents, training updates, forms and templates. This however requires a review and update to ensure that all the documents and information are current and are easily accessible for viewing by users. ***(Matter Arising 2 – Medium Priority)***

2.4 The Health Board's SharePoint page includes key documents such as:

- National Patient Safety Incident Reporting Policy (Welsh Government, May 2021);
- NHS Wales National Incident Reporting Policy Implementation Guidance Document (Phase 1);
- National Incident reporting flow chart; and
- Powys Health Board Easy guide patient safety Incident reporting at the national level.

2.5 The Health Board has several incident management guides available, however, there is currently no document in place that details the actual incident reporting processes operating within the Health Board. ***(Matter Arising 3 – Medium Priority)***

Conclusion:

2.6 Following the Welsh Government changes in incident reporting that took place in June 2021, the Health Board published a number of guidance documents, most of which are available on the SharePoint page. In order for staff to have ease of reference, a procedure or framework which provides a holistic view of the Health Board's incident reporting processes is required. Also, the SharePoint page requires updating to ensure easy navigation and accessibility of resources to staff. ***(Reasonable Assurance)***

Objective 2: Incidents are identified and responded to in a timely manner and to the required standard in accordance with the relevant legislation

2.7 Incidents occurring within the Health Board are reported on the Once for Wales Incident Management system which has a standard functionality. The Health Board went live with the datix functionality on June 14, 2021. There is an approval system in place within the Health Board when changes are identified as being required within datix, prior to their presentation at the Once for Wales Incident Functionality Group. Changes relating to the core data or data set can only be made via this group.

2.8 It is the responsibility of the staff in the service where the incident occurred to notify of its occurrence via datix and adequately complete the incident form with the relevant information. Incidents are managed at the service level and key staff have been identified within service groups to handle incident reporting. The Quality and Safety team provide continued support in order to embed robust assurance processes and learning from incidents.

2.9 Managers assign the investigators who are notified via a link within the email sent to them. The form is then changed to 'make safe'. Focused reviews via scrutiny panels are undertaken. It is also stated how long the management actions will take in days. Recommendations, lessons learnt, and date completed are also entered on the form.

2.10 Depending on the incident type entered (e.g. violence & aggression, information governance, infection prevention and control) an email is sent to the key responsible staff in the specific area. The Assistant Director of Quality and Safety-Nursing and the Safety Systems and Information Co-ordinator also receive notifications on all reported incidents via email.

2.11 A number of training sessions are available for relevant staff, these include:

- How staff can complete and submit an incident form on datix;
- Manager's training on the completion of the datix form, timeliness of completion, accuracy checks and resources available to access relevant information;
- Investigation trainings on root and causes;
- Ombudsman sessions which can be booked through the ESR system; and
- Other training courses available on ESR.

2.12 The Community Service Group (CSG) was the service area reviewed for Incident reporting management. The Number of reported incidents within CSG from January 2022 to December 2022 was approximately 1952. A number of tests were undertaken on a sample of reported incidents, including timelines in the incident reporting and management process. A number of observations following this testing have been highlighted in Appendix A. ***(Matter Arising 1 – High Priority)***

2.13 The Powys and Hywel Dda Health Board will be trialling a system commencing January 2023 to ensure the duty of candour is followed, that is providers are open and transparent with people who use services and their family members. There will

be added scrutiny to ensure the appropriate level of harm is allocated to the reported incident. These include:

- Is it accurate?
- Has the rating been changed?
- Reason for the change?

Conclusion:

2.14 Training takes place where staff are updated and advised on the requirement and expectations of the incident reporting processes. The sample tests undertaken indicated some stages within the incident reporting process fell behind expected and established timelines. ***(Limited Assurance)***

Objective 3: Incidents are reported, monitored and discussed at appropriate forums within the Health Board and are escalated where required to provide the required assurance

2.15 The Safety Systems and Information Co-ordinator produces incident reports that are presented at various groups and committees, along with a dashboard report from the business intelligence section of datix. Dashboards are developed manipulating data to meet the needs of specific service areas.

2.16 The Health Board's Integrated Quality Report (IQR) includes a serious incidents and concerns section. The reports for July, September and November were reviewed, the relevant areas of the report pertaining to the audit included:

- Reports on the current position of open NRI.
- Report on patient and non-patient safety per non, low, moderate, severe, Catastrophic & death level of harm.
- Highest reported incident themes: Pressure or moisture damage being the highest followed by trip, slip or fall.
- Tabular presentation of new incidents, make safes, incident under investigation and those awaiting closure.

2.17 The IQR is presented at the Executive Committee meeting and the Health Board's Patient Experience Quality and Safety Committee. The report is expected to go to the Executive Committee bimonthly for executive review, however September's report was not presented. ***(Matter Arising 4 – Medium Priority)***

2.18 The two highest reported incident themes are Pressure or moisture damage followed by slip, trip or fall. The following specific panels are held based on these types of reported Incident:

- There is a Pressure Ulcer Scrutiny panel that meets every month and reviews pressure related incidents and investigations;
- All trip, slip or fall incidents reported go to a weekly scrutiny panel; and
- Trip, slip or Fall incidents where there is a reported level of harm also go to a Fall Huddle group for review.

Conclusion:

2.19 The Health Board structure provides a mechanism which offers assurance on incident management through the Executive Committee and the Patient Experience Quality and Safety Committee. However, we were unable to establish a consistent/ organised route of periodic reporting and monitoring of incidents at the Community Service Group Level. ***(Reasonable Assurance)***

Objective 4: There is clear evidence of action being taken and lessons being learned and shared across the Health Board to minimise future occurrence where deficits are identified

2.20 The Incident reporting form on datix has a section where lessons learnt are to be documented. Depending on the level of harm and type of incident, the completion of the lessons learnt section might not be applicable. There is currently no mechanism in place to ensure lessons learnt as stated on datix are actually implemented at an operational level. ***(Matter Arising 5– Low Priority)***

2.21 The Integrated Quality Report (IQR) for July, September and November 2022 were reviewed. In July, there was a write up on the learning from an incident in the Quality Assurance Overview report while September and October highlighted the NRI themes for learning and improvement.

2.22 There is also a learning Newsletter produced quarterly to share learning from Incidents, concerns, Investigations, Inquests, Medicines management, Patient stories, Quality Improvements and Claims. The first issue was published in October 2022.

2.23 As noted previously, we have been unable to ascertain (within the Community Service Group) a system in place or established medium used for the communication of lessons learnt to the operational staff and group as a whole. ***(Matter Arising 4 – Medium Priority)***

Conclusion:

2.24 Lessons learnt are documented on datix and shared via a number of means at the Health Board level from reports presented at the PEQS to the learning newsletters and 7-minute briefs. Methodical Sharing has not been evidenced (via meeting agendas for instance) at the operational level within the Community Services Group. Lessons learnt are currently not monitored for actioning. ***(Reasonable Assurance)***

Objective 5: Relevant incidents, including nationally reportable incidents, are reported in a timely manner in accordance with national reporting requirement

2.25 Nationally Reportable Incidents (NRI) are required to have a rapid meeting. This is held by those 'not' directly involved in the incident. All NRI's have an executive lead allocated to the incident who chairs the rapid meeting.

2.26 Once an incident is recognised as a NRI, a NRI notification is completed and sent to the Concerns Team, the concerns team subsequently cascades this to the right person. The NRI is then submitted to the Delivery Unit by either the Lead Clinician-Quality & Safety or the Ward sister. This is proof checked by the Executive Director of Nursing and Midwifery.

2.27 The Delivery Unit generates a dashboard of how many NRI the Health Board has reported, analysed across months, severity and location. The purpose of this reporting is to ensure good governance both on the part of the Delivery Unit, responsible for the national reporting process, and individual organisational governance responsibilities in complying with the published policies and guidance.

Conclusion:

2.28 The Health Board has processes in place for the reporting of NRIs and the dashboards produced by the Delivery Unit confirm that reporting is taking place. ***(Substantial Assurance)***

Appendix A: Management Action Plan

Matter Arising 1: Outcome from CSG's Incident Reporting Review (Operation)	**Impact**
A sample of eighteen incidents was selected from the total incidents reported and closed between July 2022 and November 2022 for the Community Service Group (CSG). This period was selected for the relevant applicability of the change in policy following the publication of the Welsh Government policy in June 2021 and the migration to the new datix system which took place in April 2022. Safeguarding reported incidents were excluded because they are outside the jurisdiction of the CSG and handled differently from other CSG reported incident. The expectation of timelines stated within the WG Policy and Delivery Unit Guidance are outlined below: The Patient Safety Incidents Policy states: *'When incidents such as these (Patient safety incidents) occur, a comprehensive response is required to ensure immediate make safe actions are taken. 'Page 3* *'…..an initial 'make safe'/ 72 hour review has identified issues to trigger a patient safety incident investigation.' Page 5* NHS Wales National Incident Reporting Policy Implementation Guidance Document (Phase 1) states: *'All incidents should be subject to timely review to ensure immediate make safes are identified and actioned, to reduce future risk of patient harm where applicable, and to determine necessity for national reporting to the DU in keeping with policy timeframes.' Page 5* *'The national Incident reporting flow chart states (in regard to initial review) that management review should be undertaken at the earliest opportunity from the notification to establish appropriate categorisation, immediate actions and make safes.' Page 12* *'The national Incident reporting flow chart also states that report on datix on the earliest opportunity following occurrence or at point of knowledge.' Page 12*	Potential risk of: • Patient harm or poor patient experience • Financial loss

The table below highlights the outcome from the review of the key timelines for the reporting and investigation of the sampled incidents:

Timeline review	Number of exceptions from the sample of 18 incidents	Working days	*Days assumed as 'timely'*
Incident date to Incident reported date	1	21	*1 to 3*
Incident reported date to 'make safe' / review start date	17	8 to 102	*1 to 3*
Days Incident is closed after Investigation end date	4	7 to 35	*1 to 6*

It was observed that the incident reported date to date closed were largely influenced by, and linear to, the date reported to the review start date. This saw the three highest number of working days (incident reported date to date closed) at 103, 87 and 59.

Our review of the sampled incidents also highlighted the following issues:

- Thirteen of the eighteen incidents had lessons learnt highlighted, stating they will be communicated to their local teams and Nurses meeting. There was however no evidence provided to confirm that this had taken place;
- One of the statements under the lessons learnt was just further explaining the incident;
- For twelve of the eighteen incidents, the level of harm was moderate and one of the eighteen was catastrophic/ death. This is an indication that the Health Board has caused a level of harm in these thirteen cases. However, we have been unable to confirm from the CSG key lead if the level of harm allocated is appropriate in regard to the description of the reported incident; and
- Investigators undertake the review of reported incidents; however, we could not evidence any requirement for investigators to undertake the root course Analysis Training prior to carrying out different types and levels of investigation.

Recommendations		Priority
1.1	Management should ensure that: • All incidents are managed in accordance with the required timescales; • Staff are clear on how to assess the level of harm caused as a result of the incident • Lessons learnt only state the learning from the incident reported, communicating it to the relevant teams and groups; • Evidence of meetings held should be adequately stored for ease of future use or reference; and • Staff are Root Cause Analysis trained prior to undertaking incident investigations (where required). The formal documentation of the requirement and processes within a Health Board specific procedure (as per recommendation 2.1 below) will provide a platform where the due process can be referred to minimising the findings noted from the review.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1	Processes to ensure monitoring of timely incident management are established to escalate delays when incidents are not managed and closed within an appropriate timescale.	May 2023	Assistant Director Quality & Safety
	Additional 'Duty of Candour' training sessions have been established during February and March 2023 to ensure classification of harm is addressed appropriately by those reporting (a recording of this session is available to staff unable to attend).	Completed	Assistant Director Quality & Safety
	Clinical Service Groups to implement a structured process to share learning from incidents.	April 2023	Head of Nursing
	Complete a TNA for all staff investigating incidents to ensure appropriate training has been received.	May 2023	Assistant Director Quality & Safety

Matter Arising 2: Requirement of a Health Board Local Guide Procedure (Design)	**Impact**
The Health Board needs a procedure to provide a structured overview of the incident management process within the Health Board and support the interpretation and implementation of the National Patient Safety Incident Reporting Policy (Welsh Government, May 2021) and NHS Wales National Incident Reporting Policy Implementation Guidance Document. There is currently no Health Board specific guide outlining in one place, the Health Board specific processes or expectation relating to (and not limited to): • Other relevant policies and procedures; • Key responsibilities of staff; • Current governance arrangements as they relates to the internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes within the Health Board; and • required mechanism for demonstrating shared learning.	Potential risk of: • Non-compliance with relevant legislation

Recommendations		**Priority**
2.1	Management should work towards producing an Incident reporting Standard Operating Procedure which will bring together (in one place) a standardised and clear system.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Production of an incident management framework.	June 2023	Assistant Director Quality & Safety

Matter Arising 3: Accessibility of Incident Management Resources on SharePoint (Design)	**Impact**
The incident reporting section of the Health Board's SharePoint site requires re organisation. At the time of review, documents within the site were not categorised or organised in a user-friendly manner. More work is required to determine the best way to display the relevant information and documents under this section. At the time of the audit review, the following findings were made: • The easy guide Patient Safety Incident Reporting at the National Level was uploaded twice on SharePoint; • The HB's Serious Incident Policy is on SharePoint. Although it is still in date, it does not reflect major changes that have taken place following the issue of the WG and the Delivery Unit Incident Reporting Policy and guidance with a name change from 'serious incident' to 'Nationally Reportable Incident'; • There is a Once for Wales Concerns Management (system) guide which is updated quarterly by the Once for Wales Group. The SharePoint site has various copies of the user guide, including the current and previous version and duplicate copies of same version; and • The 'How to report a fall or pressure damage on Datix Cymru' document, though shared via email in April 2022 is not available on SharePoint.	Potential risk of: • Difficulty in staff locating available Incident management resources

Recommendations		**Priority**
3.1	Acknowledging that developing the datix and incident reporting section of the SharePoint site is a work in progress, management should ensure datix and Incident reporting related pages are reviewed to ensure relevance and ease of use.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Review the reporting section of Sharepoint to ensure appropriate and up to date information is contained within it.	April 2023	Assistant Director Quality & Safety

Matter Arising 4: Incidence Reporting and Governance Arrangements (Operation)	**Impact**
The June and November's Integrated Quality Report (IQR) that went to the Patient Experience Quality and Safety Committee (PEQS) was also presented at the Executive Committee. However, the September 2022 IQR, though taken to PEQS was not presented at the Executive Committee. The CSG Quality and Safety Group meet every two months. The August and December meetings took place while October's meeting was stood down. On review of its minutes and ToR, it was observed that: • Information or data relating to incident reporting provided in the CSG monthly Quality and safety report was presented only at the August CSG Q&S meeting. We have been unable to evidence any pattern of periodic review of incident reports or sharing of lessons learnt from incidents within the CSG. • Its ToR is not dated, and it does not state within, the expected frequency of review of incident reporting.	Potential risk of: • Inadequate monitoring and reporting can lead to further patient harm or poor patient experience.

Recommendations		**Priority**
4.1	Management should ensure there is periodic monitoring and reporting of incidents in place at the required forums. Groups should also review and update their ToR as required.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Review reporting structures to ensure consistency and robust reporting processes.	April 2023	Assistant Director Quality & Safety

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Matter Arising 5: Monitoring of Actions from Lessons Learnt (Operation)			Impact
The lessons learnt section on the incident reporting form on datix is usually completed and is documented based on the uniqueness in learning of the reported event. Depending on the type of incident, the completion of the lessons learnt section might not be applicable. Evidence from reviewing the Directorate of Nursing and Midwifery and Health Board fora shows synopsis in the identification of lessons learnt. However, there is no form of monitoring (on one system/ database) of the lessons learnt over time and actions which have been undertaken operationally to minimise future occurrence where these deficits are identified.			Potential risk of: • Reputational damage with decreased public confidence.
Recommendations			**Priority**
5.1	As a form of good practise, management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence. Through other audits undertaken, we have seen this as an area of good practise.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Review the structures in place within the service groups	May 2023	Head of Nursing & Midwifery

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17/03/2023 15:10:13

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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Audit, Risk and Assurance Committee Update – Powys Teaching Health Board

Date issued: March 2023

This document has been prepared for the internal use of Powys Teaching Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Audit, Risk and Assurance Committee Update

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board. We presented our most recent Audit Plan to the committee on March 2022.

2 We also provide additional information on:

- other relevant examinations and studies published by the Audit General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2022-23 Accountability Report and Financial Statements	Director of Finance	Statutory audit of the financial statements to inform the audit opinion.	Audit planning is underway. Year-end timetable to be discussed with management in due course.	July 2023

Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Orthopaedic services – follow up	Director of Primary Care, Community & Mental Health Services	This review examined the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are taking place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings have been summarised into a single national report with supplementary outputs setting out the local position for each health board.	National and local report published on 2 March 2023	May 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Blog and data tool published in April 2022 Project brief issued in August 2022. Fieldwork underway	May 2023
Structured Assessment	Board Secretary	This work will continue to form the basis of the work we do to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The 2022 work will review the corporate arrangements in place at the Health Board in relation to:	Draft report in clearance	May 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Governance and leadership; • Financial management; • Strategic planning; and Use of resources (such as digital resources, estates, and other physical assets).		
Primary Care Services - Follow-up Review	Director of Primary Care, Community & Mental Health Services	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. Our report published in 2019 made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Scoping	July 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Workforce Planning	Director of Workforce & OD	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Fieldwork	Project brief issued in November 2022. September 2023

Other relevant publications

6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – relevant examinations and studies published by the Auditor General

Title	Publication Date
Digital Inclusion in Wales **Key questions for public bodies**	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog **Powys Teaching Health Board – Tackling the Orthopaedic Services' Waiting List Backlog**	March 2023
Betsi Cadwaladr University Health Board – Review of Board Effectiveness	February 2023
'Together we can' – Community resilience and self-reliance	January 2023

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Audit Wales has not published any corporate documents since the last committee update.

8 **Exhibit 5** provides details of any relevant Audit Wales consultations currently underway. There are no relevant Audit Wales consultations currently underway.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.5

AUDIT, RISK & ASSURANCE COMMITTEE	**DATE OF MEETING: 21st March 2023**
Subject:	**Post Payment Verification Progress Report – 1st April 2022 to 13th March 2023**
Approved and presented by:	Director of Finance and IT All Wales Post Payment Verification Manager
Prepared by:	Amanda Legge - Post Payment Verification Manager
Considered by Executive Committee on:	21st March 2023

PURPOSE:

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle, and the two previous. It also demonstrates the overall performance of the health board against the national averages. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The past year in 2022-2023, PPV have faced challenges associated with the ability to perform 'Business as Usual' due to different factors.

To effectively respond to challenges identified within Primary Care we continued to investigate further avenues to enhance our PPV services which has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

General Medical Services (GMS): Following communications that went out on 20th December, regarding the inability to undertake the entirety of the visits on the visit plan for 2022/2023, we are planning to condense all remaining visits from the 3-year visit plan into 2-year period of 2023/24 and 2024/25.

We also experienced some transitional points with the introduction of the new payment system so a separate assurance exercise is being undertaken by our payment colleagues in SSP for the data range January 2022 to September 2022. As a result, we will begin by checking the data submitted from practices from October 2022.

The length and period of data will extend as time moves forward as it has done historically as part of the PPV assurance.

Regarding the revisits that were raised because of routine visits in the last financial year, and any outstanding visits, we will be utilising the same data, however if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.
The visit plan runs on a 3-year cycle for GMS and is agreed by Health Boards.

General Ophthalmic Services (GOS): The visit plan for GOS 2022-2023 was agreed by Health Boards after explaining that these visits were subject to change due to beginning a new way of working. PPV began remote access options having full support from Optometry Wales and begun to carry out virtual visits via Microsoft TEAMS which proved successful. Future visits will now be included in the 2023-2024 visit plan, and although we are hoping to increase the number of remote visits, we are also incorporating physical visits to carry us through this transition period of electronic claiming which is being encouraged by Welsh Government. We also continue to undertake the GOS quarterly patient letter programme across Wales to provide additional elements of assurance to our Health Boards.

Pharmacy Services (GPS): Due to COVID-19, the Medicines Use Review (MUR) service was stopped in March 2020. In 2022/23 NWSSP introduced a pilot for two new service checks by PPV, which are the Quality and Safety Scheme and the Collaborative Working Scheme. We will now be going 'Live' in April 23/24 with the Quality and Safety scheme and seeking approval for our GPS visit plan from our Health boards.

Additional Services
In 2022/23 PPV verified Bonus Payment checks as requested by Welsh Government that were claimed and paid to all Health Service staff in 2021.

We are providing a new service check for dispensing data and after a successful pilot we rolled this out nationally in August 2022 using the quarterly data form April-June 2022. This will continue as a quarterly service for all Health boards across Wales.

The GMS snapshot and statistics tab now separate the routine and the revisit errors and averages.
Revisits are generally higher percentages due to 100% of the claims checked over a longer period.

RECOMMENDATION(S):

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

The report details specific risks as outliers in a traffic light system, but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving.

Approval/Ratification/Decision[1]	Discussion	Information
✓	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:		
	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	
	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. Transforming in Partnership	
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT
Equality Act 2010, Protected Characteristics:

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

	No impact	Adverse	Differential	Positive	Statement *Please provide supporting narrative for any adverse, differential, or positive impact that may arise from a decision being taken*
Age					
Disability					
Gender reassignment					
Pregnancy and maternity					
Race					
Religion/ Belief					
Sex					
Sexual Orientation					
Marriage and civil partnership					
Welsh Language					

Risk Assessment:

	Level of risk identified				Statement *Please provide supporting narrative for any risks identified that may occur if a decision is taken*
	None	Low	Moderate	High	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

We have representatives from every Health Board in Wales and have set up a newly reformed GMS working Group. These meetings are held bimonthly and are very successful. This is to keep communications open and transparent between PPV and Health Boards whilst also collaboratively working to review specifications and ensure standardised approach for PPV remote access samples.
Hold National and local counterfraud (CF) quarterly meetings to discuss the PPV work being carried out and any issues that we feel need to be raised.This establishes excellent working communications with our CF colleagues across Wales and avoids any duplication of work.
We continue the transition into an All Wales service. This will guarantee a more robust PPV team and ensure business continuity.
We have developed a video recorded guide to PPV to aid contractors and equip them with useful information in a simplified format/update FAQ documents.
To use technology to continue one-on-one training requirements from practices that request this as this was previously undertaken in person in the practice premises.
New 360 degree PPV questionnaire released to capture feedback from our contractors after a PPV visit has taken place and the file is closed.
All PPV audit reports are sent to the Directors of Primary Care for information purposes and for feedback.
Began PPV training/Roadshow events to Practice Managers across Wales, utilising technology to host these events as opposed to ‘in-person’ presentations.
Verified contractor Bonus claims and payments to NHS staff in Wales as required by Welsh Government.
We have re-established our quarterly meeting with ourselves, Primary Care, Counter Fraud and finance in our quarterly meetings. The idea behind this being that we can decide on appropriate actions from the appropriate division for all the practices in Amber and Red.
General Opthalmic Services, we can now complete remote access PPV visits after a successful pilot. We continue to utilise trend analysis data to write out to patients to ensure they are receiving the services that have been claimed in their names.
PPV will go Live on New services checks for Pharmacy from April 2023. This is the Quality and Safety Scheme. The Pilot for Collaborative working Scheme and the is still ongoing and are hoping to go Live on this scheme at some point in 2023/24.
We are now producing reports for out HB's and practices with all relevant incorrect Dispensing Patient data. This will be a quarterly piece of work for the PPV team.

Powys Teaching Health Board

GMS PPV Progress Report: April 2022 to 13th March 2023

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

UHB Claim error % Ave	0.00%
Wales claim error % Ave	17.93%
Apr 2022 to 10th Feb 2023 recovery amount	£0.00

	Visit 1				Visit 2				Visit 3					
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors	Claim error %	Recovery
									No GMS visits undertaken in 2022/23					

Patterson,Liz
17/03/2023 15:10:13

	Health Board		
	2020/2021	2021/2022	2022/23
Number of practices visited	10	9	0
Amount of claims sampled	5,044	2,887	0
Claim errors identified	1279	272	0
Average claim error rate	25.36%	9.42%	0.00%
Recovery amount	£17,842.67	£12,005.51	£0.00

	All Wales		
	2020/2021	2021/2022	2022/2023
Number of practices visited	187	217	36
Amount of claims sampled	85,352	137,118	6,625
Claim errors identified	9,954	17,617	1188
Average claim error rate	11.66%	12.85%	17.93%
Recovery amount	£232,012.10	£370,449.00	£50,339.13

	Health Board - ROUTINE		
	2020/2021	2021/2022	2022/2023
Number of practices visited	7	4	0
Amount of claims sampled	1,377	912	0
Claim errors identified	52	40	0
Average claim error rate	3.78%	4.39%	0.00%
Recovery amount	£2,326.14	£1,595.07	£0.00

	All Wales - ROUTINE		
	2020/2021	2021/2022	2022/2023
Number of practices visited	122	138	29
Amount of claims sampled	27,804	43,958	1,355
Claim errors identified	1,635	2,681	95
Average claim error rate	5.88%	6.10%	7.01%
Recovery amount	£68,772.35	£80,442.99	£7,257.32

	Health Board - REVISIT		
	2020/2021	2021/2022	2022/2023
Number of practices visited	3	5	0
Amount of claims sampled	3,667	1,975	0
Claim errors identified	1227	232	0
Average claim error rate	33.46%	11.75%	0.00%
Recovery amount	£15,516.53	£10,410.44	£0.00

	All Wales - REVISIT	
2020/2021	2021/2022	2022/2023
65	79	7
57,548	93,160	5,270
8,319	14,936	1093
14.46%	16.03%	20.74%
£163,239.75	£290,006.01	£43,081.81

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.6

Audit, Risk and Assurance Committee	**DATE OF MEETING: 21st March 2023**
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and presented by:	Director of Corporate Governance/ Board Secretary
Prepared by:	Interim Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee 8th March 2023

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 31st January 2023.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to CONSIDER the current position of outstanding Audit Recommendations and take ASSURANCE that the organisation has an appropriate system for tracking and responding to audit recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Provide Early Help and Support	
	2. Tackle the Big Four	

	3. Enable Joined up Care.	
	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

INTERNAL AUDIT

During September 2022, an exercise was undertaken to review the revised deadlines implemented as a result of the COVID-19 priority level. Executive Owners were provided an opportunity to review any outstanding recommendations from 2017/18, and 2019/20 and re-consider where appropriate, achievable final deadlines for implementation that could be monitored against. The revised deadlines are included within the appendices. All recommendations from 2018/19 are now complete.

The reporting period 2020/21, 2021/22 and 2022/23 is summarised by Internal Audit priority level (high, medium**,** and low). This approach is being taken for all new audit recommendations received going forward.

The overall summary position in respect of **overdue** internal audit recommendations is: -

Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21	2021/22	2022/23	TOTAL OUTSTANDING
	Number				Number			Number
Priority 1	0	0	0	High	2	8	4	14
Priority 2	0	0	6	Medium	4	12	7	29
Priority 3	0	0	4	Low	1	4	2	11
Not Yet Prioritised	0	0	0					0
TOTAL	**0**	**0**	**10**		**7**	**24**	**13**	**54**

Detail of re-prioritised internal audit recommendations can be found appended to this report as follows: -

Appendix D – Internal Audit Recommendations that remain OUTSTANDING.

Appendix E – Internal Audit Recommendations COMPLETED since the previous report.

Appendix F –Internal Audit Recommendations NOT YET DUE for implementation.

EXTERNAL AUDIT

The overall summary position in respect of **overdue** external audit recommendations is: -

Overdue External Audit Recommendations						
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Priority 1	0	0	0	0	0	0
Priority 2	1	0	1	0	0	2
Priority 3	0	0	0	0	0	0
Not Yet Prioritised	0	0	0	1	1	2
TOTAL	**1**	**0**	**1**	**1**	**1**	**4**

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix G – External Audit Recommendations that remain OUTSTANDING.
Appendix H - External Audit Recommendations Not Yet Due for Implementation**.**
Appendix I – External Audit Recommendations COMPLETED since the previous report.

LOCAL COUNTER FRAUD SERVICES

There are currently no outstanding recommendations from Local Counter Fraud Services Pro-Active Exercises.

NEXT STEPS:

Progress against outstanding audit recommendations will continue to be monitored by the Executive Committee and Audit, Risk and Assurance Committee.

2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1							✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	2							✓
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0							✓
171806	Risk Management	Limited	2	1	0	2	1	0							✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0							✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0							✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0							✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1							✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1							✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0							✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1							✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0							✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1							✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3							✓
171817	Policies Management	Reasonable	0	4	1	0	4	1							✓
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3							✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1							✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4							✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2							✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3							✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1							✓
171824	General Ledger	Substantial	0	0	1	0	0	1							✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1							✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1							✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	1							✓
171828	Personal Appraisal Development Reviews (PADRs)	Reasonable	1	1	0	1	1	0							✓
171829	Records Management Follow-Up	Reasonable	1	4	2	1	4	2							✓
TOTAL			**28**	**81**	**32**	**28**	**81**	**33**	**0**	**0**	**0**	**0**	**0**	**0**	

2018/19 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
181901	IMTP – Joint Planning Framework	Reasonable	0	1	1	0	1	1							✓
181902	Dental Services: Monitoring of the General Dental Services Contract	Limited	2	2	0	2	2	0							✓
181903	ICT Infrastructure	Reasonable	0	1	2	0	1	2							✓
181904	Podiatry Service	No Assurance	7	1	3	7	1	3							✓
181905	Recruitment and Retention	Reasonable	1	2	0	1	2	0							✓
181906	Environmental Sustainability Reporting	Reasonable	0	1	0	0	1	0							✓
181907	Commissioning – Primary Care (Advisory)	Not Rated	2	2	0	2	2	0							✓
181908	Asbestos Management	Reasonable	0	4	4	0	4	4							✓
181909	Occupational Therapy Service	Reasonable	0	6	0	0	6	0							✓
181910	Health and Safety	Limited	1	6	1	1	6	1							✓
181911	Section 33 - Governance Arrangements	Limited	2	1	1	2	1	1							✓
181912	Annual Quality Statement	Substantial	0	1	0	0	1	0							✓
181913	Departmental Review - Catering	Limited	3	3	1	3	3	1							✓
181914	Capital Systems	Reasonable	0	6	1	0	6	1							✓
181915	Temporary Staffing Unit	Reasonable	0	4	1	0	4	1							✓
181916	Cyber-Security Follow-up of Stratia Report	Reasonable	0	2	2	0	2	2							✓
181917	Putting Things Right – Lessons Learned (Midwifery)	Reasonable	0	1	3	0	1	3							✓
181918	Single Tender Waivers	Reasonable	0	3	0	0	3	0							✓
181919	Business Continuity Planning	Reasonable	1	2	2	1	2	2							✓
181920	Information Governance: General Data Protection Regulation (GDPR) - Compliance	Reasonable	0	1	2	0	1	2							✓
181921	Risk Management	Limited	2	1	0	2	1	0							✓
181922	Procurement of Consultant and Agency Staff Follow Up	Reasonable	0	3	1	0	3	1							✓
181923	Medicines Management (Patient Group Directions) Follow-Up Review	Limited	3	3	0	3	3	0							✓
181924	Estates Assurance Follow Up	Reasonable	0	6	4	0	6	4							✓
181925	Capital Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
181926	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1							✓
181927	Engagement with Primary Care Providers Follow-up	Limited	1	2	1	1	2	1							✓
TOTAL			**25**	**70**	**32**	**25**	**70**	**32**							

2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	Not Yet Prioritised	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	1	0								✓
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1								✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0								✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3								✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3								✓
192006	Records Management	No Assurance	6	0	0	4	0	0	2	0	0	0	2	0	0	×
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3								✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	3	0								✓
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2								✓
192010	111 Service	Reasonable	2	3	0	2	3	0								✓
192011	Catering Services Follow-up	Reasonable	0	3	2	0	3	2								✓
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	2	3	1								✓
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4								✓
192014	Care Homes Governance	Limited	1	2	3	0	0	3	1	2	0	0	3	0	0	×
192015	Primary Care Clusters	Reasonable	1	3	1	1	3	1								✓
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	1	0	0	1	0	0	0	1	0	✓
192017	Dental Services: Monitoring of the GDS Contract Follow-up	Reasonable	0	0	2	0	0	2								✓
192018	IT Service Management	Reasonable	0	2	1	0	2	1								✓
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	1	4	1	1	4	1								✓
192020	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1								✓
192021	Capital Assurance Follow Up	Substantial	0	1	0	0	1	0								✓
192022	Outpatients Planned Activity	Reasonable	1	3	0	1	2	0	0	1	0	0	0	1	0	×
192023	Estates Assurance Follow Up	Reasonable	0	1	2	0	1	1	0	0	1	0	0	1	0	×
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1								✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0								✓
192026	Risk Management and Board Assurance	Limited	2	3	0	2	2	0	0	1	0	0	1	0	0	×
192027	Welsh Language Standards Implementation	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0	×
192028	Section 33 Governance Arrangements Follow Up	Reasonable	0	2	1	0	2	1								✓
TOTAL			**23**	**63**	**32**	**20**	**57**	**31**	**3**	**6**	**1**	**0**	**6**	**4**	**0**	

2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0				✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	2	5	0				✓
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	3	2				✓
202104	Annual Quality Statement	Not Rated	0	1	0	0	1	0				✓
202105	Advanced Practice Framework	Not Rated										✓
202106	Capital Systems	Substantial	0	0	4	0	0	4				✓
202107	GP Access Standards	Substantial	0	0	1	0	0	1				✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	1	1	1	2	0	0	×
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	14				✓
202110	Freedom of Information Follow Up	Substantial										✓
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	0	2	0	0	0	0	0	2	0	×
202112	Grievance Process	Reasonable	0	1	0	0	1	0				✓
202113	Safeguarding during COVID-19	Reasonable	0	1	1	0	1	1				✓
202114	Implementation of digital solutions	Reasonable	0	3	0	0	3	0				✓
202115	Winter pressures and flow management	Reasonable	0	3	1	0	1	0	0	2	1	×
202116	Llandrindod Wells Project	Limited	0	5	1	0	5	1				✓
202117	Covid-19 Mass Vaccination Programme	Not Rated										✓
TOTAL			**5**	**26**	**25**	**3**	**22**	**24**	**2**	**4**	**1**	

2021/22 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	H	M	L	
212201	Access to Systems	Reasonable	1	1	1	1	1	1							✓
212202	Control of Contractors	Limited	4	2	1	4	2	1							✓
212203	Medical Equipment and Devices	Reasonable	3	3	1	0	0	0	3	3	1	0	0	0	×
212204	Midwifery – Safeguarding Supervision	Reasonable	0	2	0	0	1	0	0	1	0	0	0	0	×
212205	COVID Recovery and Rehabilitation Service	Substantial	0	1	0	0	1	0							✓
212206	Theatres Utilisation	Reasonable	2	2	1	0	0	0	2	2	1	0	0	0	×
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	2	1	1	1	0	0	0	0	×
212208	Waste Management	Reasonable	0	5	0	0	4	0	0	1	0	0	0	0	×
212209	Job Matching and Evaluation Process	Reasonable	0	2	1	0	2	1	0	0	0	0	0	0	✓
212210	Mortality Review	Reasonable	0	5	1	0	5	0	0	0	0	0	0	1	×
212211	Machynlleth Hospital Reconfiguration Project	Reasonable	1	5	1	1	5	1							✓
212212	Network and Information Systems (NIS) Directive	Reasonable	0	3	1	0	3	1	0	0	0	0	0	0	✓
212213	Budgetary Control	Substantial	0	1	0	0	1	0	0	0	0	0	0	0	✓
212214	Occupational Health Service	Limited	1	0	0	0	0	0	3	0	0	0	0	0	✓
212216	Risk Management and Assurance	Reasonable	0	3	1	0	2	0	0	1	1	0	0	0	×
212217	Breathe Well Programme	Substantial	0	3	1	0	2	0	0	1	1	0	0	0	×
212218	Recommendation Tracking Process & Follow Up Review	Substantial	0	0	2	0	0	1	0	0	1	0	0	0	✓
TOTAL			**13**	**42**	**13**	**6**	**31**	**7**	**9**	**10**	**5**	**2**	**0**	**1**	

2022/2023 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	H	M	L	
222301	IT Infrastructure and Asset Management	Limited	4	3	0	0	0	0	0	0	0	4	3	0	×
222303	Security Services	Reasonable	1	5	0	0	2	0	1	2	0	0	1	0	×
222304	Staff Rostering	Reasonable	0	2	0	0	2	0							✓
222305	Control of Contractors	Substantial	0	1	0	0	1	0							✓
222306	Decarbonisation	Not Rated	0	0	3	0	0	1	0	0	0	0	0	2	×
222307	Looked After Children Health Assessments	Substantial	0	1	0	0	0	0	0	1	0	0	0	0	×
222308	Cancer Services -Access to Symptomatic FIT	Substantial	0	1	1	0	1	1							✓
222309	Women's and Children's Services	Substantial	0	0	2	0	0	1	0	0	0	0	0	1	×
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	0	2	1	0	1	0	0	1	1	0	0	0	×
222311	North Powys Wellbeing Programme	Reasonable	2	3	2	2	1	1	0	1	1	0	1	0	×
222312	Charitable Funds	Reasonable	0	1	2	0	1	0	0	0	0	0	0	2	×
222313	Workforce Futures	Reasonable	0	2	2	0	0	0	0	2	0	0	0	2	×
222314	Welsh Language Standards	Limited	5	3	0	0	1	0	3	0	0	2	2	0	×
TOTAL			**12**	**24**	**13**	**2**	**10**	**4**	**4**	**7**	**2**	**6**	**7**	**7**	

2018/19 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			All Audit Recs Implemented
					1	2	3	
181951	Structured Assessment 2018	12	11	1	0	1	0	×
181952	Clinical coding follow-up review	4	4					✓
181953	Audit of Financial Statements Report	4	4					✓
TOTAL		**20**	**19**	**1**	**0**	**1**	**0**	

2019/20 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			All Audit Recs Implemented
					1	2	3	
192051	Structured Assessment 2019	3	3					✓
TOTAL		**3**	**3**	**0**	**0**	**0**	**0**	

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	2	3	Not Yet Prioritised		
202151	Effectiveness of Counter-Fraud Arrangements	3	3							✓
202152	Structured Assessment 2020	11	10	1	0	1	0	0	0	×
202153	Audit of Accounts	6	6							✓
TOTAL		**20**	**19**	**1**	**0**	**1**	**0**	**1**	**0**	

2021/22 External Audits

	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	2	3	Not Yet Prioritised		

212251	Structured Assessment 2021 (Phase One)	0								✓
212252	Structured Assessment 2021	3	3							✓
212253	Audit of Accounts Report - Charitable Funds and Other Related Charities	3	2	1	0	0	0	0	0	×
TOTAL		**6**	**5**	**1**	**0**	**0**	**0**	**0**	**0**	

2022/23 External Audits

	Audit Title	**Audit Recs Made**	**Audit Recs Implemented**	**Audit Recs Overdue (agreed timescale)**	**Audit Recs Revised Re-Prioritised**				**Audit Recs Not Yet Due**	**All Audit Recs Implemented**
					1	**2**	**3**	**Not Yet Prioritised**		
222301	Reviewing Public Bodies' current approach for conducting	1	0	0	0	0	0	0	1	×
222302	The National Fraud initiative in Wales 2020-21	3	0	0	0	0	0	0	3	×
222303	Review of the Strategic Renewal Portfolio	5	4	1	0	0	0	0	0	×
TOTAL		**9**	**4**	**1**	**0**	**0**	**0**	**0**	**4**	

APPENDIX C

Local Counter Fraud Services Pro-Active Exercises

Ref	**Audit Title**	**Audit Recs Made**	**Audit Recs Implemented**	**Audit Recs Overdue (agreed timescale)**	**Audit Recs Not Yet Due**	**All Audit Recs implemented**
202181	Pre-Employment Checks	3	3			✓
212281	Overpayments	3	3	0	0	✓
TOTAL		**6**	**6**	**0**	**0**	

PTHB Ref. No.	Report Title	Assurance	Director	Responsible	Ref.	Recommendation	Management Response	Agreed	Revised	Due	COVID-19	Status	If closed and not	Progress being made to implement recommendation	If action is complete	No. of	No. of	Reporting	Date Added to
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R4	Management need to ensure that all prospective employees are cleared on a timely basis following receipt of the pre-employment questionnaires so that they can commence employment as soon as possible.	Develop a set of KIPs and implement monitoring of compliance against timelines relating to Occupational Health Pre-employment checks	Oct-22		Overdue		No progress		Appropriate KPIs will be developed following 3 month period of monitoring trends Sept-Nov. FEBRUARY '23 KPIs will form part of the new OH mgt system (CIVICA) due to go live in 2023. There will be a a set on all Wales KPIs and dashboards to utilising once all HBs have moved to the new system in 2023. We are currently capturing timeline data that we will use in the interim to assess effectiveness of PECS.	hold up in system is immunisations declarations -and timeliness of employees returning information – Reliance on managers to chase employees to source and send information to OH	Pre-employment checks are now triaged within 3-4 working days.	End Q3		3		Jan-23	Aug-22
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R6	Management should consider developing the current dashboard to include any indicators around timeliness of services provided by Occupational Health.	Occupation team will develop a set of KIPs to be included in the Occupational Health reporting dashboard for: • Timelines and compliance relating to OH referrals and appointments • Timelines and compliance relating to OH Pre employment checks	Oct-22		Overdue		No progress		Detailed dashboard yet to be developed- Reliant of above KPI data sets to be fully in place. FEBRUARY '23 KPIs will form part of the new OH mgt system (CIVICA) due to go live in 2023. There will be a a set on all Wales KPIs and dashboards to utilising once all HBs have moved to the new system in 2023. We are currently capturing timeline data that we will use in the interim to assess effectiveness of PECS.	This information will then be included in the Monthly HR workforce dashboard	Verbal updates at H&S group Data on referrals and PECs to be included when available in WOD workforce performance report dashboard	End Q3		3		Jan-23	Aug-22
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads	R3	All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service governance leads in the form of self-audits. Governance leads will provide assurance to the Medical Devices Group through "At a Glance Reports."	Nov-21	Feb-22	Overdue		Partially complete		Examples of evidence received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document to be presented to MD&POCT Group in March 2023 for approval across all services. Full implementation can then take place.	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.	Examples of evidence received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document to be presented to MD&POCT Group in March 2023 for approval across all services. Full implementation can then take place. Audits will be required to monitor compliance. These will need to be service led as there is no capacity within the Medical Devices Team to undertake these.		14	11	Jan-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Head of Clinical Education / Medical Device & POCT Manager	R5	1. The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 2. The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	1. Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group is scheduled for 8th November, this was delayed at the request of Clinical Education as waiting for new members of the team to commence into post. The aim of the group will be to pilot a process for a small number of devices. Once this is in the place, the same process will be rolled out for all devices and all staff groups. 2. Management will ensure manufacturer's instructions are stored digitally via the Medical Devices Intranet page where applicable. Capacity to undertake this task is limited. Responsibility for this role and timeframe for completion to be identified.	Mar-22		Overdue		Partially complete		Training matrix has been developed and shared with Governance Leads for review. Shared with MD&POCT Group members in October 2022 and agreed at November MD&POCT Group. Comments received and to be added to matrix.	Resource within Medical Devices Team.	Implementation of new devices on a health board basis incorporate training and recording via ESR.	Assurance on devices already in use will take some time to obtain through ensuring all staff are appropriately trained and competent, recieve updates at agreed intervals and that robust recording processes are in place. Gradual progress being made but unable to define a specific completion date due to capacity constraints		10		Jan-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R6	The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (kpi's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (PPM Contracts) • Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The renewal of the main maintenance contract (due 1st April 2022) provides an opportunity to significantly strengthen this area. Standing agenda item will be added to the Medical Devices Group to review contract monitoring and KPI's.	Apr-22		Overdue		No progress		Contract monitoring meetings continue with some providers. Temporary additional resource has provided an opportunity to strengthen processes in this area and identify cost savings. Additional resource has also enabled contract monitoring meetings to be reinstated. However, this won't be feasible in the long term without permanent support in this area.	Resource prevents progress in this area.	Contract monitoring meetings held for some providers.	Without any additional support it is difficult to understand how the health board will be in a position to strengthen contract monitoring processes and therefore obtain assurance on compliance.		9		Jan-23	
212204	Midwifery – Safeguarding Supervision	Reasonable	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding supervision / Assistant Director for Women and Children's services	R1	1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives 1c. Requirements to attend Safeguarding supervision and available dates for Q3 are highlighted through the Midwifery Weekly brief that is shared to all Powys Midwives 2a. Safeguarding supervision compliance will be monitored through monthly Midwifery Management and Leadership Governance meeting and has been included into the Women and Children's Senior Leadership Performance Dashboard 2b. Women and Children's Safeguarding Work plan to be reviewed and updated to ensure improvements with compliance is effectively implemented	Dec-21		Overdue		Partially complete		Ongoing highlighting to midwives at a range of forums re compliance with safeguarding supervision. Lead midwife for safeguarding to commence in post 29/08; workplan to include support for supervision. * Rachel Mills lead Safeguarding Midwife will attend monthly Management & Leadership meetings to update the team on Safeguardng cases. * Abbi Maddox Interim Head of Midwifery & Sexual Health to meet with Rachel Mills Safeguarding Midwife on a monthly basis to be sighted on training and required updates. * Learning to be embedded through Joint Shire Meetings with Midwifery & Health Visiting services using Safeguarding scenerios on a quarterly basis. Feb 2023 - update - change in senior management team in January 2023 - management meeting weekly agenda amended to ensure sfaeguarding supervision compliance and any specific updates are standard agenda 2nd week of the month from now on. Safeguarding midwife has database of attendnace at quarterly sessions which will be shared with managment team at those meetings also supporting mechanism for escalation B7 team leads will be expected to feed back monthly on compliance on many elements including safeguarding for their teams safeguarding midwife also booked for March 2023 all Powys team meeting to provide further update for staff around safeguarding advise further embedding of process	Issues regarding release of staff due to staff shortages/clinical demand Limited number of sessions which are not always available when convenient for all staff to attend	request that team leads allocate protected time for staff to attend which is rostered, preventing clinical work to be allocated to individual. Lead midwife for safeguarding, to commence in post 29/08, who will support midwives to attend Midwives aware can access safeguarding team re any concerns about specific cases	Expected improvement in compliance by end of Q3; Monitored via Safegaurding Strategic Group and added to W&C dashboards. Feb 2023 - expcted improvement by April 2023 in view of changes in senior structure in Jan 2023		13		Jan-23	
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director Community services	R3	The Service Level Agreements for the in-reach staff should be reviewed and updated as soon as possible.The assumptions and calculations within management information should be reviewed and updated as soon as possible. Agreed Management Action 3	To review service level agreement with in reach providers, this is challenging due to current seasonal pressures focus and all providers re-aligning/transforming services and implanting recovery plans. Management reports will be aligned with updated SLAs as part of 2022/23 service planning.	Mar-22		Overdue		Partially complete		All SLAs to be by the end of Sept as part of managing the overall financial position of the HB. Update - revised focus at CQPRM meetings will see SLA performance discussed more frequently including supplementary operational meetings. There remains a certain level of fragility in the inreach relationships due to at times, a higher level of need withiin the host provider. Feb 23 update - CQPRM meetings include enhanced oversight. the Commissioning Team's programme of work for 23/24 includes a formal review of this area and the application of a consistent approach to all inreach SLA's			01/07/2023		10		Jan-23	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director of Community services	R4	The actions put in place should continue to be monitored to ensure that they mitigate the risk of failing to achieve access targets including Referral to Treatment and National Endoscopy Programme Joint Advisory Group Training Site re-accreditation.	Plans in place monitored via Delivery & Performance Committee and Diagnostics, Ambulatory Care & Planned Care Board Programme, PTHB Integrated Performance Report.	Ongoing		Overdue		Partially complete		Additional reporting in place and PTHB continues to review compliance against JAG standard. 1 unit now JAG accredited with the 2nd unit seeking accreditation during 22/23			01/04/2023		#VALUE!	#VALUE!	Jan-23	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Operations Manager, Mental Health Services	R2	The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee.Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the operational updating of the WCCIS System.	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 – day basis we will require two flow charts demonstration patient flow and the method of referral.The SOP requires finalisation and until full expansion of the service will require two sections, relating to North and South Powys. This will include an update on WCCIS forms to be utilised, however, it should be noted that this work is conducted on an all-Wales basis and all agencies using WCCIS are required to agree to the same forms and processes.	Apr-22		Overdue		Partially complete		Strong progress has been made on the SOP, and updating WCCIS forms is underway. However, these need to be agreed at a national level before they are implemented.	Authorisation of new forms at a national level.	Paper forms are currently in use.	TBC - as working to national WCCIS team deadlines.	Jun-23	3		Jan-23	Jan-22

212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R1	The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The THB should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements. The new document, once approved, should be published online. Superseded documents should be removed from the intranet.	Agreed. The core document is already in place and is currently out for consultation with Waste Group members. Agreed. The updated document will be signed off as a Policy at Executive Committee.	May-22	Dec-22	Overdue		Partially complete		Some further changes to the document are required. The document will then go through the process that will close with consideration by the Board. We have reviewed the document following completion of our contract award, but also reflected on progress in other HBs -and our document will be finalised and through necessary governance by December 2022	Obtaining an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the revised document by the Board. Extention to deadline requested due to committee timetables.	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	Nov-22		8	1	Jan-23	Apr-22
212216	Risk Management & Assurance	Reasonable	Board Secretary		R2	A programme of risk management training should be rolled out across all tiers of Health Board management and staff so as to provide theoretical and practical knowledge to support the content of the Risk Management Framework.	Recommendation Accepted A proposed approach was considered at the RAG on 5 July with further development of training material agreed to be presented back to its next meeting prior to roll-out into the organisation to relevant groups. Risk Management Training is available for staff to access via ESR but a more tailored approach to the Health Board's specific requirements is required and in development.	Oct-22		Overdue		Partially complete		Feb 2023 - training material is in development. Roll out has not yet commenced due to staffing changes, wil continue from 1 May 2023.					3	3	Jan-23	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R4	Management should update the Project Initiation Document (PID) to reflect the current workstreams. The revised PID should then be submitted for formal approval at the appropriate meeting.	PID to be updated to reflect the current workstreams. PID to be agreed by Breathe Well Programme Board at September 2022 meeting and then approved by RSPB thereafter.	Oct-22		Overdue		Partially complete		PID to be updated to address issues identified through Internal Audit and to reflect change from RSPB to Transformation & Value Committee Meeting (name TBC). Draft PID scheduled for comment by Breathe Well Programme Team on 14/09/22 and for approval by Breathe Well Programme Board on 30/09/22.		Managed through Breathe Well programme governance	Approved by Breathe Well Programme Board on 30/09/22 and will then go for Executive Committee approval on 9 November 2022.	The updated PID, Breathe Well Programme Team and Breathe Well Programme Board minutes and the Transformation & Value Group Exec Committee minutes can provide evidence.	3		Jan-23	Aug-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation			If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?				
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and how feedback received has been incorporated into the policy. The recommended consultation period of a minimum of 14 days should be applied to ensure that consultation with relevant stakeholder groups has been conducted thoroughly and that comments have been incorporated into the policy.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Mar-23	Complete	2	Complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors. Feb 2023 - The Policy was approved by the Board in November 2022 and reflects the actions recommended in the audit. Roll out across the organisation including awareness raising and use of the toolkit will continue into 2023/24.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Jan-23	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content checks have been carried out.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. As set out in recommendation 4 below, the ability to upload polices onto the intranet will be restricted to members of the Corporate Governance Department.	May-18	Mar-23	Complete	2	Complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors. Feb 2023 udpate - this action is complete and in place.	N/A as action complete	N/A as action complete	Sep-22		46	#NUM!	Jan-23	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. Going forward policies submitted to the Corporate Governance Department without the submission and approval form will be returned to the relevant Executive Director.	May-18	Mar-23	Complete	2	Complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors. Feb 2023 udpate - this action is complete and in place.	N/A as action complete	N/A as action complete	Sep-22		46	#NUM!	Jan-23	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate Governance Department. The Policy and Procedures Index should be published on the intranet at regular intervals and consideration given to widening the scope of this document to include polices which are due for review.	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed and will be updated by the end of April 2018.	Apr-18	Mar-23	Complete	2	Complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors. Feb 2023 upate - once policies are finalsied theya re published within 5 days wherever possible.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		47	#NUM!	Jan-23	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	May-18	Mar-23	Complete	2	Complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme. Feb 2023 update - action complete	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Jan-23	Feb-19
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Board Secretary	Board Secretary	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability framework and governance systems for HRCW. (c) The health board ensures that the Welsh Government Hosting Agreements, and any signed replacement agreements, for the hosted functions are shared with all those health board staff managing and monitoring services provided to these hosted functions.	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to inform arrangements for other hosted arrangements, including HCRW.	Apr-20	Mar-23	Complete	3	Complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement which was complete; however this work was then superseded by the intended transfer to the Citizens Voice Body in 2022. Renewed discussions are taking place in line with organisational governance to review the current position in relation to Health Care Research Wales and advice on hosting agreement is being sought from NWSSP Legal and Risk Services. Both aspects will be overseen by the Audit, Risk and Assurance Committee. Feb 2023 update - recommend this action is closed, this action has been superceeded by the creation of the CVB (Lais) which transfers out of Powys THB on	N/A as action complete	N/A	N/A	Yes	33	#NUM!	Jan-23	
212214	Occupational Health Service	Limited	Director of Environment	Assistant Director of Support Services	R5	The Health Board need to ensure that Health Surveillance is embedded within the Health Board so that a review of all staff that require health surveillance is undertaken and those that require it are assessed as and when required in compliance with Health and Safety Executive requirements. Management need to ensure that Hiring Managers are aware of the need to complete the Health Surveillance section on the pre-employment check form.	A 'task and finish' review of roles that require health surveillance will be commissioned through the Health & Safety Group, chaired by the Assistant Director for Support Services. Departmental and Service representatives will be asked to submit roles in their department that are subject to Health Surveillance for the risks identified in H&S regulations. The group will review Job Descriptions for the said roles to ensure that Health Surveillance requirements are reflected in the role, and to advise Occupational Health.Hiring managers will be reminded via a communication to be cascaded through the Deputy and Assistant Directors of the requirement to complete the Health Surveillance section of the Pre employment check form. Workforce Business Partners and Assistant Business Partners will also be asked to remind hiring managers of the importance of completing this section too.	Sep-22		Complete		Complete		A proforma for assessing roles for Health Surveillance has been developed and is in use. All Job Matched job descriptions in Estates, Support Services and Operating Theatres have been assessed against each of the Health Surveillance domains. Occupational Health have received this feedback. Maternity, Radiography and Dental will be asked to do the same for all job matched roles in those departments. This will complete review of the departments with significant Health Surveillance risks. The Health Surveillance working group will take advice on which departments should be approached next, if any. Communications have been circulated regarding the refreshed Health Surveillance Occupational Health checking forms for new starters.	None identified	Completed	Oct-22	Evidence of work completed to date can be provided.	4		Jan-23	Aug-22
212216	Risk Management & Assurance	Reasonable	Board Secretary		R1	Future iterations of the Risk Management Framework should be supported by an awareness exercise and ensure dissemination of the documentation to Directorate senior management so they can cascade the information to their staff accordingly and reduce the potential of inconsistent or inadequate risk management practices across the Health Board.	Recommendation Accepted It should be noted, however, that members of the current RAG are aware of the risk management framework, as are all Board members. Wider awareness throughout the organisation can always be improved and accept that future iterations should have a proactive awareness exercise in place to support them.	Dec-22		Complete		Complete		Feb 2023 - revised risk management framework approved by Board in Nov 2022, executive team and risk and assurance group fully engaged. Awareness raising will continue into 20223/24 and will cross over into risk management training. Asction closed on this basis.					1	1	Jan-23	Aug-22

212216	Risk Management & Assurance	Reasonable	Board Secretary		R3	The Corporate RAG ToR document should be updated accordingly to reflect organisational changes and approach to risk governance since 2019.	Recommendation Accepted The TOR of the RAG were considered at its meeting of 5 July 2022 and it was agreed that generally they remain fit for purpose. However, a wider review of risk management arrangements is due to conclude in November 2022 when the review of the Risk Management Framework is due to be reported to the Board of which the role of RAG will be updated as required.	Nov-22		Complete		Complete		Feb 2023 - action complete				Yes	2	2	Jan-23	Aug-22
212218	Recommendation Tracking Process & Follow Up Review	Substantial	Board Secretary	Head of Corporate Governance Manager	R1	Going forward, management should work with the Committee members to consider ways in which the level of scrutiny and challenge, particularly around overdue recommendations, can be increased. This could include requiring the relevant Executive leads to attend the Committee to provide further assurance around the plans in place to ensure implementation of overdue recommendations.	The Board Secretary will work with Committee members to encourage and increase the level of scrutiny and challenge in relation to audit recommendations, particularly those overdue. A review of long-standing overdue recommendations is being undertaken and where considered appropriate Executive Leads will be invited to the relevant Committee to provide further assurance around progress and plans in place. As an example, an update on Records Management is to be reported to the next meeting of the Delivery of Performance Committee.	Jul-22		Complete		Complete		Feb 2023 - actions have been taken as outlined in column H, action closed on that basis recognising levels of reporting, scrutiny and review will need to be maintained.					6	6	Jan-23	Aug-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R2	The risk associated with old equipment should be fully explained at the corporate level. The failure to utilise the end of year funding to remove old network devices should be stated to the Delivery and Performance Committee.	As Above 1.1 and regular updates are provided to the Exec Director of Finance, and as part of the Digital First updates to D&P committee. Partly Agreed - The comment to D&P was to recognise the investment made and how this has helped to improve the position (replacement kit / solar winds etc) but was not to say that all issues are fully resolved. Required plan and action will be across a number of years. This is also reported in the delivery against plan as part of the Digital First objective 'Digital Infrastructure' on the IMTP Will also be updated as part of a Digital Board Development Day	Dec-22		Complete		Complete		A rolling hardware refresh is in place and all hardware recorded on a Asset Solution (SysAid)					1	1	Jan-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R3	Alerts should be configured within devices to enable active management. The thresholds for the alerts should be set accordingly. The Health Board should utilise Solar Winds to manage alerts.	Monitoring of the network is led by the Digital Transformation Team (previously under S33 arrangements) and this has been enhanced by the deployment of Solar Winds (secured with DPIF funding in 21/22), continued action in place to fine tune the configuration to maximise functionality and enable proactive alert management. Thresholds are regularly reviewed and improved to allow effective management of alerts and issues as reported.	Dec-22		Complete		Complete		Solar winds fully implemented and alerts configured. Those alerts are regularly reviewed to ensure the threshhold set is actively proactive to improve the management of issues reported					1	1	Jan-23	Sep-22
222303	Security Services	Reasonable	Director of Environment	Assistant Director of Support Services	R1	Management should provide a refresher training session for all Departmental Managers regarding the Security Policy.	The PTHB Security Protective Measures Policy (FTP005) has been reinstated on the PTHB Intranet and Sharepoint Site for reference. This action will be discussed further during the next Security Oversight Group Meeting in December with the meeting invitation distribution List extended and updated to include a wider representation from all Departments across PTHB. A 30 minute slot has been reserved on the agenda for the next Site Coordinators Meeting and Health & Safety Groups in January 2023, to discuss the Security Protective Measures Policy and to deliver the toolbox talk on the preparation of Departmental Security Plans. An internal communication will be made to all Departmental Managers advising them of the latest version of the Security Protective Managers Policy and its location on Sharepoint	Feb-23		Complete		Complete		Toolbox talks have been provided via SOG Security Oversigte Group Audit Action Plan presented and ratified by the Health and Safety Group. A baseline knowledge awareness survey for department managers is being provided for managers in March 2023 to assess their knowledge prior to Security Policy Refresher Sessions date being delivered.					#NUM!	#NUM!	Jan-23	Nov-22
222304	Staff Rostering	Reasonable	Director of Workforce and OD	Assistant Director of Workforce and OD	R1	Management should remind roster creators and clinical service managers that rosters must be created, approved and published in a timely manner in line with the Rostering Policy and the HealthRoster timetable.	A monthly monitor compliance report against the Rostering policy will be produced for all rosters and shared with senior managers to ensure monitoring and corrective actions are being taken in a timely manner. The roster timetable will be reissued to all senior managers and roster managers.	Nov-22		Complete		Complete		Compliance reports are produced and shared with senior managers which includes data around monthly rosters and weekly finalisation. The roster timetable has been re-issued to all managers and they can also see the dates on the unit summary within the Healthroster.					2	2	Jan-23	Nov-22
222304	Staff Rostering	Reasonable	Director of Workforce and OD	Assistant Director of Workforce and OD	R2	Clinical Service Managers and Roster creators should liaise with the E-Systems Implementation Officer to ensure that the rules and parameters within the HealthRoster system for all areas are up to date and working effectively to ensure maximum utilisation of the benefits and features of the "auto-roster" functionality of the system.	All duty rules against rosters will be reissued to ward managers to review and updated on the system to reflect current roster practice. Refresh training will be offered to all ward managers. Roster rules will be reviewed with the ward managers twice a year to ensure they remain up to date.	Dec-22		Complete		Complete		E-Rostering Team have met with all ward managers to review roster rules, and these have been updated against the units in Healthroster. Refresh training has been offered out to the Wards and going forward it will be offered out to the other areas.					1	1	Jan-23	Nov-22
222305	Control of Contractors	Substantial	Director of Environment	Director of Environment	R1	Local site signing in requirements should be consistently applied across the THB. Induction information should be enhanced to ensure contractors are informed of local site signing in requirements prior to attending site.	Communications to be issued to hospital management to reinforce the importance of all Contractors following the signing-in protocols for fire safety/security reasons; signing in books for Contractors have been distributed to main Receptions at hospital sites. Estates Induction Training for Contractors to emphasise message around appropriate local sign-in at sites being visited for fire safety/security purposes.	Oct-22		Complete		Complete		Signing in process in place					3	3	Jan-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Environment	Head of Technical Services	R4	Management should adapt and update the existing risk management tool to bring together the various risks associated with the implementation of the decarbonisation agenda.	There is a need to be consistently clear about risks to delivery and any need for mitigation or adjusted timelines. The detail of the exception reporting and necessary mitigating steps will be increased for future Environment Sustainability Groups It is necessary to note however that a specific risk register for decarbonisation will not be created and risks should be included in any departmental risk registers	Dec-22		Complete		Complete		Enhance exception reporting means created and will be adopted going forward					1	1	Jan-23	Nov-22
222308	Cancer Services - Access to Symptomatic FIT	Substantial	Medical Director	Transformation Programme Manager	R1	Management to reiterate to Wye Valley Trust the need for the breakdown in figures in order to establish if the pathways are clear to all primary care providers and are being followed.	Secure from Wye Valley NHS Trust on a monthly basis the required breakdown of data in relation to the tests issued.	Jan-23		Complete		Complete		Feb 22. Action is complete					0	0	Jan-23	Jan-23
222308	Cancer Services - Access to Symptomatic FIT	Substantial	Medical Director	Transformation Programme Manager	R2	Management should review the membership of the Programme Board within the Programme Initiation Document to establish if it remains appropriate.	Review membership of the Cancer Renewal Programme Board within the Programme Initiation Document to establish if it remains appropriate. Any changes to the membership of the Board to be agreed at the next Cancer Renewal Programme Board meeting being held on 17/1/23.	Jan-23		Complete		Complete		Feb 22 - membership reviewed and agreed at Cancer renewals programme board					0	0	Jan-23	Jan-23
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	Director of Environment	Project Director	R1	C ost reports should be included in every Project Board agenda, to enable appropriate scrutiny in accordance with the terms of reference.The scheduling of Project Board meetings should take account of the wider project and cost management timeline, to ensure key reports are available for timely inclusion in the agendas.	Client appointed Cost Advisor cost reports will be provided for review in advance of Project Board meetings to enable full and appropriate scrutiny.	Dec-22		Complete		Complete		Project Board meeting schedule reviewed to ensure 1 week post progress meeting to allow all documentation to be provided prior to PB meetings. External consultants advised of deadline for papers	N/A	Reliant on external consultants			1	1	Jan-23	Jan-23

222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	North Powys Wellbeing Programme Senior Responsible Officer	R1	Acknowledging that there have been slippages in timeline as a result of a number of factors, Management should ensure that the 2022/23 programme plan is finalised as soon as possible so as to lead and direct the management, monitoring and reporting of the programme for the current period.	Draft Programme Plan issued to all workstream leads to confirm timescales and a request made to have any amends comments 2 weeks before Programme Board approval. Ongoing monthly monitoring against plan will be done via the submitted workstream dashboard reports and reporting by exception into Programme Delivery Team	Jan-23		Complete		Complete		Plan has been produced but there is in year slippage due to staff turnover and part deferral of some of the workshops. On occasions the Delivery Team meeting has been stood doen due to Quoracy issues					0	0	Jan-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R2	Management should ensure there is a standardised and robust system in place for the adequate monitoring of projects. Management should endeavour to carry over lessons learnt from the untimely achievement of some of the engagement and communication plans, where relevant applying its implementation to future plans.	In 21/22 a Results Based Accountability (RBA) approach was adopted however 22/23 is a period of transition to RIF reporting as requested by Welsh Government. Before our accelerated projects commenced 20 -21, a new process was established, Theory of Change, Business Case, which all completed and submitted for approval by Programme Board. All projects developed milestone plans, performance measures and a finance plan. These were monitored monthly through an update all provided, plus quarterly through meetings where leads from the project, finance and data all discussed delivery and performance. Project Monitoring system in place will report to the Programme Board on an exception basis if milestones are not being met. Of the three actions that are overdue: 1&2 - The issues papers and surveys (which are interlinked) are progressing but are taking longer than initially anticipated. 3 - The other overdue issue is the updating of the website. This will be done as a matter of priority by 31/03/23.	Jan-23		Complete		Complete		Complete on the basis that Internal Audit have undertaken a review of process during 2022 and given a 'reaonable assurance' rating					0	0	Jan-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R3	As a form of good practise, it will be beneficial for management (with the ease to view trends) to highlight within the reports where little or no changes have occurred from the previous reporting period.	The projects share updates each month, many of our projects had recruitment delays (National Staffing issues) which impacted on progress, and the content of what was included in the report. Project leads to be advised only to report on the current period not any historical information already included on previous reports and to clearly state where little or no change has occurred since the last reporting period.	Dec-22		Complete		Complete		As above					1	1	Jan-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R4	a) Management should ensure the risk register is kept up to date and reviewed quarterly. The recommended deep dive following the stocktake reporting should be promptly undertaken. All Programme risks highlighted in the programme, project, workstream or relevant reports should be recorded in the risk register. b) As noted at the Programme Board, an informed decision should be reached regarding the management and escalation of outliers to the risk appetite. c) The system for collating risks is currently manageable, however, a programme of such magnitude is bound to have a relative increase in risk in the near future. As a forward-looking approach, management should consider a sustainable format specifically where the Programme may likely be exposed to more risks as it progresses into further stages in the life cycle of the programme.	a) A Review of the risk register has taken place at the Programme Board held 30/09/2022 and the risk register has been updated to take into account recommendations. It was agreed to hold full review at Programme Board 6 monthly with the risk being monitored via Programme Delivery team on a monthly basis. b) To be included on a future Programme Board Agenda to discuss a management and escalation plan moving forward. c) Appointment of a Senior Capital Programme Manager has been completed. A sustainable format specifically where the Programme may likely be exposed to more risks as it progresses into further stages in the life cycle of the programme will be reviewed. A detailed workplan capturing all the interdependencies across the whole programme, through monthly reporting into Programme Delivery Team and Programme Board will be established.	Mar-23		Complete		Complete		Risk Register has been developed and in use at the Programme Board meetings					#NUM!	#NUM!	Jan-23	Jan-23
222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Charity Manager	R1	Management should consider incorporating references to related polices / guidance within the Charitable Funds Policy and update accordingly. Once updated the policy should be approved by the appropriate forum and staff made aware of the updates	Agreed – The policy recommendations have been actioned, reviewed and approved by the Charitable Funds Committee since the fieldwork, in December 2022. The updated policy will be published and disseminated to staff once the formal minute has been confirmed.	Jan-23		Complete		Complete		Policy approved at Dec 22 Charitalble funds Committee and is on intranet site for staff use					0	0	Jan-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R7	Management should undertake work to raise the Welsh Language Team profile and promote their Share point page. They should ensure that there are links to various sources of information, advice, and services that are available whilst helping to promote and encourage the use of the Welsh language within the workplace. The Share Point page should also be populated as soon as possible to provide advice and information to staff members which outlines their responsibility and have clear signposts to where they can obtain help or clarity.	Welsh Language sharepoint pages are live and will be regularly updated. Sharepoint pages have been 'launched' on our weekly newsletter Announcements. Service managers to highlight Welsh Language pages to teams via all channels	Jan-23		Complete		Complete		Sharepoint Page is now populated.					0	0	Jan-23	Jan-23
212207	Dementia Services-Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Business Manager, Mental Health	R4	Management must ensure that the Performance measures are subject to appropriate independent review prior to submission.Good practice in data collection should be shared between the teams.	This process will be reviewed to ensure that Performance Measures are independently and rigorously tested prior to submission.The MHLD business manager will facilitate the sharing of good practice within data collection, including a common method to capturing and processing information.	Mar-22		Complete		Complete		Significant work has been completed in relation to this action, in terms of data cleansing. From April 23, New National MH outcomes mreasurements will be implemented across Wales, and the MH team are working towards this implementation. During the period October to March 23, the service will be preparing to embed the new performance measures.	Developments are required to WCCIS on a national level to capture this data.		Mar-23	May-23	3		Jan-23	Jan-22
212207	Dementia Services-Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Assistant Director of Mental Health Services	R5	A review of the performance measures should be undertaken to ensure they are meaningful, and duplication is avoided.Guidance on how to interpret and evidence the performance measure should be provided. Management should consider standardising the performance measures across both teams to ensure meaningful and comparable information is collected.	The review of performance measures will be undertaken as part of a wider MHLD service group's participation in Welsh Government's move to service user led outcomes and core data sets.Within the National move to service user led outcome and data sets, training for staff and managers on its collation and interpretation will be facilitated on a National Basis, and PTHB are currently involved in this work.Local performance measurements will be developed and utilised on a pan Powys basis to improve performance and ensure that consistent, accurate and meaningful information is collected to improve performance.	Sep-22		Complete		Complete		Please see above as this is a similar reccomendation.	See above.	See above	Mar-23	May-23	3		Jan-23	Jan-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R2	Management should ensure that an appropriate audit trail is maintained of all changes agreed/proposed to activities listed in the programme plan.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	Oct-22		Complete		Complete		Programme plan narrative will be updated for Breathe Well Programme Team on 14/09/22 and for approval by Breathe Well Programme Board on 30/09/22.		Managed through Breathe Well programme governance		Programme Plan will provide evidence.	3		Jan-23	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R3	Management should ensure that more detailed information is outlined within the progress tab in Phase 2 of the Programme Plan. The live document should be utilised to keep up to date information which provides accurate and descriptive records which is reported to the Programme Board and advises them of the current status of each work activity within the Breathe Well Programme. Where work activities are deemed as complete, there should be more detailed information within the Progress Tab to validate this.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	Oct-22		Complete		Complete		PID not considered by Executive Committee in November 2022 due to the Accelerated Sustainable Model programme work. This has allowed for a further addition to the PID about the Wellbeing of Future Generations (Wales) Act 2015 as required by the Audit Wales findings from its audit of the Renewal Portfolio. This version of the PID will be considered for approval by Transformation & Value Group Executive Committee on 09/03/23.		Managed through Breathe Well programme governance		Programme Plan will provide evidence.	3		Jan-23	Aug-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
212210	Mortality Review	Reasonable	Medical Director	MDT review panel/learning group	R5	With the Medical Examiners Service shortly taking over the process of providing Stage 1 mortality reviews, the Health Board may want to use the Learning from Experience Group for discussing any feedback that is provided to identify whether there are any issues that could be quickly resolved i.e. missing documentation, illegible notes, missing patient / doctor information. Likewise, the Health Board may want to consider reporting Stage 2 reviews to the Learning from Experience Group in the same way.	Learning will be fed back to individuals and teams where appropriate. Themes and significant issues will be discussed and shared more generally via the MDT review panel and learning group.	ongoing		Not yet due		Partially complete		This has been considered I the learning from experience group. The MDT review team is under development with the first cases to be discussed by the learning group as pilot. Several methods of feedback have been agreed - including power hour presentations, 7 minute briefings and Q&S newsletter. These will be rolled out as the ME process procedes. 14/10/22 Processes defined and in place, ME service not fully implementated across the Health Board. As numbers raise systems are in place for learning and feedback. Feb 22. ME process fully rolling out. Feedback mechanisms maturing and learning will be			Feb-23		#VALUE!	#VALUE!	Jan-23	Apr-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R1	A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.	Original replacement plan was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Secured DPIF Capital funding in 21/22 to help improve and enhance current infrastructure (but not to fully rectify and resolve), global market conditions and supplier delays resulted in alternative plans being deployed (linked to infrastructure development) to maximise use of the funding as available within time constraints. Further DPIF bids are being prepared for submission in 23/24 and beyond. There are also plans to move to the HCI platform to allow the legacy equipment to be decommissioned. This will also improve power and cooling.A realistic infrastructure replacement plan is being developed linked to the 4C report and this will be across a number of years and potential funding sources available.	Mar-23		Not yet due		Partially complete		2008 servers identifed and some have already been upgraded/migrated and there is a plan to refresh all Windows 2008 servers					#NUM!	#NUM!	Jan-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R4	A process for ensuring patching of switches should be established.	Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid.	Mar-23		Not yet due		Partially complete		Capital is sourced to replace part of the switch estate. Further funding is being sought for ongoing Switch replacement					#NUM!	#NUM!	Jan-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation / Assistant Director of Estates and Facilities	R5	Fire and water detection should be included at both sites. Consideration should be given to providing a dedicated power supply to the Bronllys room. Fire suppression should be installed at Brecon. The air conditioning within Brecon should be reviewed to ensure it is capable of reducing the temperature appropriately.	Fire detection and suppression are in place at Bronllys, but no water detection. Air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient There are plans to move on premise servers held within the Data Centre to the cloud so this will reduce the risk of on-premises DC's.A plan will be developed with Estates and Facilities to assess the water detection requirements and to test and provide assurance relating to the power requirements (initial meeting already taken place).	Mar-23		Not yet due		Partially complete		a full audit has been completed of comms rooms, there will be a report available with requirements to be submitted to estates and facilities					#NUM!	#NUM!	Jan-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R6	A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network A review and associated upgrade of Wi-Fi provision should be undertaken	Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Mar-23		Not yet due		No progress		Project manager is in post and working with suppliers on the specificaiton and quality control for cabling requirements					#NUM!	#NUM!	Jan-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R7	The network should be split into Vlans. The firewalls should be deployed.	Network re-design plane is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	Mar-23		Not yet due		Partially complete		The firewalls have been deployed and there is a design plan to segment the network and implement V-Lans					#NUM!	#NUM!	Jan-23	Sep-22
222303	Security Services	Reasonable	Director of Environment	Assistant Director of Support Services	R3	Management should consider reviewing all Security Plans at least annually at an appropriate forum such as the Security Oversight Group.	Security plans will be reviewed annually through the governance structure which will consist of the Security Oversight Group, The Health and Safety Group and the Site Coordination Forum. Security plans will be completed and filed centrally using Sharepoint, to ensure that Departments are referencing up to date policy documentation and forms.	Dec-23		Not yet due		Partially complete		Business cycle from April 2023 will include cycle of site based audits for review by the group to establish annual reviews					#NUM!	#NUM!	Jan-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Environment	Director of Environment	R1	PTHB should look to formalise Decarbonisation oversight arrangements within the Terms of Reference of existing committee/ meetings.	The Environment Sustainability Group (chaired by the Director of Environment) provides escalate/exception reports to the Innovative Environments Group (chaired by CEO) and then on to the Delivery and Performance Committee.When terms of Reference are reviewed at normal intervals the need to be more specific about reporting detail will be considered.	Oct-23		Not yet due		Partially complete		ToR for ESG will be updated in Q2 for approval by Q4					#NUM!	#NUM!	Jan-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Environment	Director of Environment	R2	The governance arrangements surrounding the respective work groups assigned specific initiatives and corresponding actions should be aligned to those set out in the paper presented at the Innovative Environment Group, with enhanced accountability for delivering plans formally set out.	This action will be considered when a new version of the Decarbonisation Plan is developed. The current plan does have actions through to 2030 however there is a current expectation that a revised plan will be submitted as part of the IMTP planning cycle for 2024/25 onward. It is however necessary to not focus all actions on decarbonisation and climate impact on a single plan if we are to embed the issue in all departmental plans.	Dec-23		Not yet due		No progress		Outcome will be dependent upon changes made during 2023					#NUM!	#NUM!	Jan-23	Nov-22
222309	Womens and Children's Services	Substantial	Director of Primary, Community Care and Mental Health	Assistant Director of Womens and Childrens Services	R1	Team Leaders should ensure that Return to Work Interview Forms are completed and signed off by both parties as soon as is practicable upon a staff member's return to duty.	We acknowledge that on this occasion the forms weren't completed as per policy and will endeavour to improve on this moving forward, however the sample period was during a time of operational challenge.	Mar-23		Not yet due		No progress							#NUM!	#NUM!	Jan-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R5	An updated benefit framework should be developed to ensure clarity and relevance to the phase of the Programme but most importantly to meet with the overall desired outcome of the North Powys Wellbeing Programme	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	Dec-23		Not yet due		No progress							#NUM!	#NUM!	Jan-23	Jan-23
222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Head of Financial Services	R3	Whilst Gift Aid claims can be submitted to HMRC on a quarterly basis, management should consider submitting the Health Board's claim at least annually.	Agreed - Gift aid claims will be undertaken on at least an annual basis	Jun-23		Not yet due		Partially complete		Claim submitted Feb 23 includes upto Sep 22. Further claim to be made Q1 23/24 for final 6 months of financial year					#NUM!	#NUM!	Jan-23	Jan-23

222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Head of Financial Services	R5	Management may wish to consider the development of a sign off checklist to concisely summarise when supporting documentation was completed and where it is located.	Agreed a template will be developed and retained for approvals and subsequent actions and dates taken on these approvals	Mar-23		Not yet due		No progress		Work underway in developing this anticipate no issues with achieving deadline ofMar 23					#NUM!	#NUM!	Jan-23	Jan-23
222313	Workforce Futures	Reasonable	Director of Workforce and OD	Strategic Workforce Lead for Health, Care & Partnership and Workforce Futures Business Managter	R3	Consideration should be taken to having other named representatives to attend the Workforce Futures Programme Board on behalf of the actual representatives when they are unable to attend the meetings, to ensure that the Board meets bi-monthly going forward. The Workforce Futures Programme Board should report into the Powys Regional Partnership Board on a regular basis in line with the terms of reference. In cases where they have nothing to report they should confirm this.	This will be an agenda item at the next Board and oversight groups to ensure named representatives attend and/or provide a deputy with approved decision making authorisation. The Workforce Futures Programme Board will submit an update progress report into the Powys Regional Partnership Board twice per year.	Mar-23		Not yet due		No progress							#NUM!	#NUM!	Jan-23	Jan-23
222313	Workforce Futures	Reasonable	Director of Workforce and OD	Strategic Workforce Lead for Health, Care & Partnership and Workforce Futures Business Managter	R4	The Workforce Oversight Group should ensure that they carry out the work that is required to be undertaken as directed by the Strategic Workforce Futures Programme Board	Actions allocated to the oversight group from WFF Board should be tracked and reported as part of the WFF highlight report at each meeting.	Jul-23		Not yet due		No progress							#NUM!	#NUM!	Jan-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R2	Management should ensure that they meet with all service action leads on a regular basis to review and note progress on the compliance of standards noted in the action plans. This will then help to inform the overall compliance position noted in the Standards Monitoring Document maintained by the Welsh Language Department.	Senior Managers to ensure Welsh is a recurring agenda item in their regular service meetings. Service managers to ensure good attendance at quarterly Welsh Language service leads meetings quarterly. Escalate attendance issues or other areas of concern to senior managers, ADs & DDs. Welsh Language team to update the Standards Monitoring Document quarterly following meetings with service areas.	Mar-23		Not yet due		Partially complete		First Quarterly meeting scheduled for 15th March.					#NUM!	#NUM!	Jan-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R5	Looking forward to the production of the Welsh Language Report for 22/23 management should ensure that appropriate engagement takes place with the Leads for each Service action plans to ensure that the position is appropriately reflected within the report.	Updates for the Welsh Language annual report and items to be included discussed regularly with the service leads Welsh Language contacts in quarterly meetings. Information collated for the annual report by the Welsh Language team and checked with services prior to presenting to Execs.	Mar-23		Not yet due		No progress		This will be a point for the Agenda on 15th March.					#NUM!	#NUM!	Jan-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R6	A review of all temporary signage should be carried out across the Health Board. The Welsh Language team should liaise with the Estates Department and all Service Leads / Responsible officers to determine the most common temporary signage that are used in their Service Groups and across the Health Board. Signposts to these bilingual signs should be available on both the Estates and Welsh Language Share point pages to direct staff to the most common signs, but also highlight who they can contact if they need help to translate any other temporary signs.	Signage guidance and Library of temporary signage up on Welsh Language Sharepoint pages. Welsh Language team to join the Estates away day in October 2022 to discuss sharing Resources and linking on sharepoint. Test & Learn of audit of signage to be undertaken by the Therapies Department. Each service area to do an audit of their own areas/ wards to check temporary signage and update (audit tool to be developed following pilot with Therapies). Good practice shared by the Welsh language team across other departments. Welsh Language team to check areas and wards on their roadshows during.	Mar-23		Not yet due		Partially complete		Welsh langauge team joined the estates away day in October 2022. Common signage list has been drawn up and is undergoing translation; initial informal audits are taking place as part of the Roadshows.					#NUM!	#NUM!	Jan-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R8	In light of the issues regarding Welsh Language Standards compliance identified in this report management should review the risk assessment for CRR 012 – Compliance with Welsh Language Standards, to establish if the position that has been/ is being reported is accurate or whether it may be overstating the current controls in place. Management should also consider where issues regarding compliance with the standards are identified in individual service action plans management should undertake risk assessments to determine if the matter should be considered a risk and added to the departmental risk register.	Welsh Language discussed internally with DoTHS. Reviewed Quarterly. Welsh Language Team to meet with Senior Managers to discuss including Welsh Language Standards on departmental risk registers.	Jul-23		Not yet due		No progress							#NUM!	#NUM!	Jan-23	Jan-23

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
181951	Structured Assessment 2018		Board Secretary		R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Overdue	2	Partially complete		Remains under review - with the approach to stakeholder engagement being formalised. Feb 2023 update - status remains as reported above, the action will form part of the 2023/24 work programme which will consider the most appropriate mechanism to achieve the aims and objectives of a Healthcare Professionals Forum. REVISED DATE REQUESTED of 30/9/23	Delayed in light of COVID-19 and changes in the corporate team	Clinical and Stakeholder engagement is undertaken via other means	30-Sep-23		39	22	Jan-23	
202152	Structured Assessment 2020		Board Secretary		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	•Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.	Mar-22		Overdue	2	Partially complete		See R2 above Feb 2023 update - as above in R2, REVISED DATE REQUESTED of 30/9/23	See R2 above	See R2 above	See R2 above		10		Jan-23	
212253	Audit of Accounts Report -Charitable Funds and Other Related Charities		Director of Finance, Information and IT		R1	We have recommended to the Charity that a more suitable financial system (ie using an accruals basis) be used in future years to reduce the risk of material misstatements of this nature going forward. The Charity have informed us that they are already in the process of moving to the same financial system as the Health Board, and that the new system will be in place for the preparation of the 2021-22 financial statements.	For the 2021-22 Charity Accounts, the Oracle financials ledger system will be used. This will be further expanded to include ordering and electronic payments to be implemented during the 2022-23 financial year.	Sep-22		Overdue		Partially complete		Work is progressing as planned, testing complete and system is going live from October with furtehr testing of ledger and payments and ordering.	This work is being prioritised for completion.	Governance and control maintained during system implementation	Anticipated end September as planned		4	4	Jan-23	Jun-22
222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R1	Independent members were engaged in the development of the Annual Plan for 2021-22 and the renewal priorities. However, since this time there has been a change in the independent member cadre. The Health Board should refresh the independent member awareness. This would ensure new and existing members have continued ownership, knowledge, and challenge.		Ongoing		Overdue		Partially complete		As part of IMTP planning for 23/24 and the wider focus on system working, PTHB has embarked on a piece work look at long term sustainability of services. This piece of work titled "Accelerated Sustainability Model" will include a review of our Strategic Renewal Portfolio			By end of Mar 23		#VALUE!	#VALUE!	Jan-23	Jan-23

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
222301	Reviewing public bodies' current approach for conducting EIAs				R4	While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach.	Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	Ongoing		Not yet due		Partially complete		Process has been reviewed and an EIA process now in place and being rolled out across teams	None		fully rolled out by Qtr 1 23/24		#VALUE!	#VALUE!	Jan-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R1	All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.		Ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	Jan-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R2	Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.		Mar-23		Not yet due		Partially complete							#NUM!	#NUM!	Jan-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R3	Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.		Ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	Jan-23	Nov-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
181951	Structured Assessment 2018		Board Secretary		R4	The Health Board's internet pages do not provide access to current policies such as the counter fraud policy. The Health Board should update its internet site to provide easy access to current policies and strategies.	The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	Oct-19	Dec-21	Complete	2	Complete		Progress has been made through the introduction of Sharepoint and significant work on the backlog of policy review within the organisation. The Health Board's main policies should now be available on the intranet and when searched for. Further work to be completed in order to close the recommendation fully. Feb 2023 - work now complete	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	31-Dec-22		39	13	Jan-23	
181951	Structured Assessment 2018		Board Secretary		R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21	Complete	3	Complete		Report templates are being reviewed as part of establishment of committees for 2022-23 and the development of a number of reporting templates for cyclical reporting and assurance reports. Feb 2023 - this work has been completed on so far as the identified action and therefore closed. To note further work will take place in 2023/24 as part of our ongoing governacne developments to further strengthen the reporting and paper presentation arrangements.	COVID-19 arrangements have taken priority over this work.		31-Dec-22		43	22	Jan-23	
202152	Structured Assessment 2020		Director of Nursing & Midwifery		41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received six formal concerns about commissioned services in quarter one. Work is ongoing to improve effective management of concerns as the Health Board has found it difficult to meet the target of responding to 75% of formal concerns within 30 working days.	•Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Complete		Complete		Paper to Clinical QG Group and EQS next week, shows progress in some areas, and other areas affected by COVID-19. CQFIP up to 2022. Update August 22, Improvement plan in place and refreshed in August 2022, this will be presented to PEQS in September 2022. It is recognised that due to small number of formal concerns maintaining a complianc of 75% compliance will be challenging. It therefor important to recognise when concerns are complex with multiple providers when reviewing compliance. This workplan is a regular agenda item at PEQS.	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021. Update August 22, complexities of concerns usually incorporating multiple commissioned services impacts compliance, English Trusts are not bound by PTR regulations.	Implementation overseen by QGG and EQS. Update August 22, maintaining regular communication with those raising the concern.			10		Jan-23	
212252	Structured Assessment 2021		Board Secretary		R1	The Health Board is experiencing a period of significant change within its independent members cohort. Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them. To supplement the national induction programme, the Health Board should develop a local induction training programme as soon as possible to help new independent members ease quickly into their role.	Review and strengthen the induction arrangements for Independent Members to improve early understanding of corporate business. To include: •Background information on establishment of the health board •Good governance and structure of Committees •Board Assurance Framework •Cycle of meetings and Terms of Reference •Roles and responsibilities •Declarations of Interest and Standards of Behaviour •Strategic Plans •Role of Charity Trustees •Means of accessing further information on the Health Board	Mar-22		Complete	2	Complete		Work is nearing completion following consultation with IMs of the material to be made available through induction and an ongoing IM library of important reference materials. Feb 2023 - this work has been completed with the exception of the BAF which wioll be developed in 2023/24.		Induction meetings with the Board Secretary, Executive Directors and other senior staff cover the items listed in the management response and independent members have ongoing support available in respect of any areas where training or awareness needs are identified	30-Sep-22		10		Jan-23	
212252	Structured Assessment 2022		Board Secretary		R2	The Health Board does not currently have any associate Board members to assist it in carrying out its functions. Previously the Corporate Director (Children and Adults) from Powys County Council was as associate Board member but has not attended. The Health Board should work with Powys County Council to identify a suitable replacement as soon as possible.	Review and strengthen the induction Interim Board Secretary will engage with Powys County Council's Monitoring Officer to identify a replacement Associate Director.	Mar-22		Complete	2	Complete		Corporate Director (Children and Adults) appointment delayed pending appointment within Powys Council but has been re-energised followig appointmet to the role in the Council - expected to be able to conclude the appointmet by the end of the calender year. Feb 2023 - Associate Director (CHildren and Adults) confirmed in post by the Minister from 1 January 2023.		Regular liaison is undertaken with the County Council and more formally through JPB and RPB.	31-Dec-22		10		Jan-23	
222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R2	The Chief Executive currently chairs both the Renewal Strategic Portfolio Board (RSPB) and the Renewal Portfolio Core Group (RPCG) which are both decision-making groups. To enable better delegation and ownership to senior executives and allow the Chief Executive and independent members to challenge senior executives more effectively and independently, we recommend that the Chief Executive does not act as Chair for one, or both groups		Ongoing		Complete		Complete		The Renewal Portfolio Core Group no longer exists					#VALUE!	#VALUE!	Jan-23	Jan-23
222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R3	The stand-alone governance structure in place for the renewal portfolio is disproportionately large when compared against the scale of the individual programmes/projects and associated funding. We recommend that the Health Board either streamlines the governance structure, or uses the structure to support other projects, including the wider delivery of the Integrated Medium Term Plan.		Ongoing		Complete		Complete		The governance structure has been reviewed with all oversight via various sub-committees of the Executive Committee					#VALUE!	#VALUE!	Jan-23	Jan-23
222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R4	The renewal portfolio is constantly being reviewed and developed, allowing for an agile approach but there is a risk that the core aims of the portfolio are lost. We recommend that the Health Board remains alert to the core aims of the renewal portfolio, and that these are adhered to as they try and remain flexible to project need.		Ongoing		Complete		Complete		Complete. Where renewal schemes are being scoped, this includes a deliverable of being able to embed the scheme within a "business as usual" mode of operation. This allows the team to move onto the next project and remain agile.					#VALUE!	#VALUE!	Jan-23	Jan-23

222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R5	Whilst reporting provides a strong narrative on the progress made in delivering the renewal priorities, the links between the key actions, progress made and the impact on outcomes is not apparent. We recommend that the Health Board strengthens its reporting by: a. revisiting key actions and milestones to ensure they are clearly defined, can be measured effectively, and have smart links to the wider strategic vision; and b. introducing a tracker report which clearly sets out actual progress against planned activity, and a RAG rating system to help identify challenges and issues.		Ongoing		Complete		Complete		Where Renewal Portfolio actions have been included as part of the IMTP, the quartely reporting process includes an update on actions to deliver the change. In addition there are progress report updates as part of the governance mechanism of the Renewal Team's ways of working.					#VALUE!	#VALUE!	Jan-23	Jan-23

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item 3.7

AUDIT, RISK AND ASSURANCE COMMITTEE	**Date of Meeting: 21 March 2023**
Subject:	**ANNUAL GOVERNANCE PROGRAMME Q2 UPDATE**
Approved and Presented by:	Director of Corporate Governance and Board Secretary
Prepared by:	Interim Head of Corporate Governance Interim Corporate Governance Manager
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with the Q3 position regarding progress with the Annual Governance Programme

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee takes ASSURANCE from the position.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	

	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

The Annual Governance Programme is a comprehensive programme of improvement in the governance arrangements of the health board. Progress is reported regularly to the Executive Committee and to the Audit, Risk and Assurance Committee.

The latest update at Q3 shows the following progress made since the last report:

- development of induction for Independent Members;
- preparations for recruitment of IM, Finance;
- visits to sites across the County by the CEO, Chair and Vice-Chair;
- Board approval of the revised Policy Management Framework; and
- Board approval of the revised risk management framework and risk appetite statement.

Limited progress has been made in formalising partnership governance arrangements which needs to be an area of focus going forward, linked to the Corporate Risk Register, together with development of the Board Assurance Framework.

Progress continues to be made in a number of other areas but they are not yet complete.

The Director of Corporate Governance is currently reviewing the Annual Governance programme, in line with the Integrated Medium Term Plan for 2023-26 and will be presenting a revised plan in 2023/24.

NEXT STEPS:

The Annual Governance Programme will continue to be reported regularly to the Audit, Risk and Assurance Committee on a regular basis, noting a revised plan is currently being developed for 2023/24 onwards.

ANNUAL GOVERNANCE PROGRAMME

MILESTONES

2022/23

Quarter 3 Update

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
1. 2. ENSURING CLARITY OF PURPOSE, ROLES, RESPONSIBILIIES AND SYSTEMS OF ACCOUNTABILITY								
a) Ensure that key supporting documents of the Board's governance framework continue to be fit for purpose at all levels, i.e. Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers	Adopt amendments to Standing Orders, as per nationally-led work	Director of Finance & IT (SFIs)						Action Complete – Approved by Board 28th July 2021.
	Review the Board's Scheme of Delegation and Reservation of Powers to ensure it reflects Executive Director portfolios and Board Committee arrangements for 2021/22							Scheme of Delegation and Reservation of Powers reviewed and revisions approved by Board May 2022.
	Board Scheme of Delegation and Reservation of Powers presented to Board for approval							
	Adopt revised Standing Financial Instructions as per nationally-led work							Action Complete – Approved by Board 28th July.
	Undertake an assessment of compliance with Standing Orders							Ongoing with reporting developments identified and implemented.
b) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of	Organisational Structures to be confirmed via Organisational Realignment Working Group	All Executive Directors						Work was underway to map organisational governance arrangements at a
	Levels of accountability, authority and autonomy to be confirmed							

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
the organisation, along with strengthened internal control	and aligned to organisational policies and frameworks							Directorate/Team level to inform deployment and accountability arrangements. This work has been paused and will be reflected in the new 2023/24 plan.
	Directorate Deployment and Accountability Frameworks to be developed, aligned to the Board's Scheme of Delegation and Reservation of Powers							
c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Identify all existing partnerships and collaborations to inform development of a Framework	Director of Planning & Performance						Overview of partnership governance arrangements presented to board at Strategic Planning Session and Planning, Partnerships & Population Health Committee.
	Mapping of these partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes							
	Development and population of a Partnership Register							Due to capacity constraints, development of the Partnership Governance
	Development of the Partnership Governance Framework for presentation to Board in							

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
	September 2022							Framework has been delayed but is in the work programme for 2023/24 and also an IMTP priority.
d) Further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship	Embed Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee	n/a						Discussions are taking place nationally with regard to the development of electronic recording of interests. Work is also underway to develop an all-Wales Policy.
	Fully implement an electronic system to support recording and reporting of declarations made							
3. 4. ENSURING BOARD EFFECTIVENESS								
a) Review and strengthen the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure	Review committee structure for implementation in 2021/22	Chair/Committee Chairs						Action Complete – Approved by Board 28th July 2021.
	Review committee terms of reference and operating arrangements with any changes presented to Board for approval in May 2021							Action Complete – Approved by Board 28th July 2021.
	Review committee membership with any changes presented to							Action Complete – Approved by Board

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
	Board for approval in May 2021							28th July 2021.
	Fully populate committee workplans, aligned to the Corporate Risk Register and Board Assurance Framework, for Board approval in May 2021							Action Complete – Approved by Board 29th September 2021.
b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals' Forum (HPF) and the Stakeholder Reference Group (SRG)	Review Terms of Reference and membership of the Stakeholder Reference Group	• Director of Planning & Performance (SRG) • Clinical Directors (HPF)						Research has been undertaken regarding the benefit to the health board of these fora in addition to existing engagement arrangements. Paper to be produced outlining the approach to engagement to crystallise this research into a decision on whether these fora are to be implemented. This work has not progressed since the last update.
	Meeting of the SRG to be held							
	Appoint Chair of the SRG as an Associate Member of the Board							
	Review current engagement mechanisms with professionals to inform approach to HPF							
	Terms of Reference and Membership of HPF to be developed							
	Inaugural meeting of HPF to be held							
	Appoint Chair of the HPF as an Associate Member of the Board							

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
c) Ensure openness and transparency in the conduct of board and committee business	Review effectiveness of live streaming board meetings	Chair						Live streaming of board meetings continues. Arrangements for members of the public to observe committees in place, in the absence of live streaming. Papers published to website as routine.
	Consider accessibility of those committee meetings required to be held in public	Director of Corporate Governance						
	Ensure meeting agendas, papers and summary notes are published in a timely manner							
d) Further improve the quality of information to the Board and its Committees	Board & Committee report templates to be reviewed to ensure assurance reports are distinguished from reports for management	Director of Corporate Governance						Report templates have been made, further changes will follow in 2023/24.
	Report Writing and Presentation Masterclasses to be held for senior management team, via the Management Development Programme	Director of Workforce & OD						Due to capacity constraints, this work has been delayed.
e) Implement an annual development programme for board members, focussing on awareness sessions as	Board review of effectiveness to be undertaken in April 2022	• Chair • Director of Workforce & OD						Board review of effectiveness undertaken in Board Development session undertaken

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
well as training and learning to support the development of individual roles and the board as a cohesive team								in April 2022 and are scheduled to take place on an annual basis.
	Implement a programme of development and a programme of briefings for 2022/23							A list of potential sessions is maintained by the Corporate Governance Team. Board Development and Briefing Sessions are being delivered on a regular basis to the areas of greatest need which are currently finance and service development.
	Ongoing implementation of an Executive Director Development Programme							Programme of development ongoing.
	Design and implement training and development for Independent Members							IM specific training to be developed to supplement development of the

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
								programme of induction.. This will form part of the wider Board Development plan for 2023/24.
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required	Work with Public Bodies Unit to prepare and deliver recruitment campaigns for upcoming vacancies	Director of Workforce & OD						IM Finance recruitment campaign to commence in may 2023. ..
	Implement an Induction Programme for Board Member appointments when required							WG Induction Programme in place. Local Induction arrangements have been developed including a Board Member library of key documents and policies and an induction pack.
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and	Design and implement a schedule of visits to a range of clinical and non-clinical services and county-wide health board sites	• Chair • Chief Executive						Some CEO/Executive Director visits re-commencing. The Chair and Vice-Chair

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
engagement								have undertaken a number of visits over the last year. Further work to be undertaken to ensure all Board members have opportunity to undertake visits.
h) Review and implement arrangements for the development, review, approval and publication of policies delegated by the Board	Policy Management Framework to be reviewed, confirming policy approval routes	Executive Director Policy Owners						The Policy Management Framework was agreed at Board in November 2022. The Policies section of the intranet has been refreshed. Work is ongoing in relation the Policy toolkit and a training programme
	Policies section of intranet/internet to be refreshed							
	Policy toolkit to be rolled out with awareness raising							
	Training programme to be developed and implemented to support the organisation in developing and reviewing policies							
i) Review Board Champion Roles, ensuring clarity on purpose and responsibility	Review delegation of Champion roles to Board Members	Chair						Board Champion roles clarified at March 2022 Board meeting. A further
	Adopt role specifications for Champion roles							

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
	Establish reporting arrangements for Champions to Board							review is required. Reporting arrangements to be established.
5. 6. EMBEDDING AN EFFECTIVE SYSTEM OF RISK AND ASSURANCE								
a) Ensure that the Risk Management Framework continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	Undertake an Annual Review of Risk Management Framework, ensuring alignment with the Board's Assurance Framework Principles	Director of Corporate Governance						A reviewed and refreshed Management Framework and Risk Appetite Statement was approved by the Board in November 2022.
	Risk Management Framework to be updated to reflect Risk Appetite Statement							
	Establish Committee Risk Registers							Committee priorities informed by strategic risks (corporate risk register). Further work required to refine operational risk registers to inform committee risk registers.
b) Promote a Risk Management Toolkit to support staff in	Publish a Toolkit including the process for escalation and de-escalation, examples of best	n/a						A Risk Management Toolkit has been developed and

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
the identification, recording and management of risk	practice to support moderation and consistency in measurement							published to the Health Board's Intranet and will also be promoted through the Risk & Assurance Group, constituted by key leaders within the organisation. Periodic recommunication will be undertaken as highlighted by the recent internal audit review.
	Toolkit to be updated in line with review of Risk Management Framework, Risk Appetite Statement and Board Assurance Framework Principles.							
c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks	Risk Appetite Statement to be considered by Board in June 2021	n/a						A reviewed and refreshed Management Framework and Risk Appetite Statement was approved by the Board in November 2022.
	Revised Statement to be presented to Board in July 2021 for approval							
	Corporate Risk Register, Risk							Revised Corporate

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
	Targets to be reviewed to ensure alignment with the Board's Risk Appetite							Risk Register reported to Board September 2022.
	Risk Management Framework to be updated to reflect Risk Appetite Statement and communicated with the organisation							A reviewed and refreshed Management Framework and Risk Appetite Statement was approved by the Board in November 2022.
d) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints System [DATIX])	Risk Management Module to be developed in-line with Once for Wales Management System Programme, in readiness for implementation in 2022	n/a						Once for Wales Management System implementation underway, aligned to national work. Risk & Assurance Group continues to meet where possible to maintain focus on operational risk management.
	Maximise the role of the Risk and Assurance Group to drive forward improvements in risk reporting arrangements							
e) Embed the Board's Assurance Framework, aligned to the Corporate	Undertake an Annual Review of Assurance Framework Principles, ensuring alignment with the	n/a						The Board Assurance Framework is in the

KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status					Comments
			Q3 (21)	Q4 (21)	Q1 (22)	Q2 (22)	Q3 (22)	
Risk Register and Organisational Risk, where appropriate	Board's Risk Management Framework							process of being reviewed. The Board continues to receive its Corporate Risk Register at each meeting and Board/Committee priorities have been determined based on risk. This is an IMTP priority for 2023/24.
	Board and committee workplans aligned to Assurance Framework							
	Assurance Framework updated quarterly, in-line with integrated performance reporting and delivery of audit programmes							
f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.	Establish Assurance Maps to identify assurances in place and any gaps in place at 1st, 2nd and 3rd line of defence for those responsibilities delegated to Executive Directors	All Executive Directors						This work has been delayed in light of the pandemic. However, work in relation to delegation and accountability arrangements continues (as per action 1b).
	Gaps in assurance to inform the Board's Assurance Framework							

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8

Audit, Risk and Assurance Committee	**Date of Meeting: 21st March 2023**
Subject:	**IMPLEMENTATION OF WELSH HEALTH CIRCULARS**
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Interim Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee on 8th March 2023

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHCs).

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to discuss the current position, considering those WHCs where no progress has been made and take ASSURANCE that the organisation is managing Welsh Health Circulars appropriately.

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	✖
	2. Provide Early Help and Support	✖
	3. Tackle the Big Four	✖
	4. Enable Joined up Care	✖
	5. Develop Workforce Futures	✖
	6. Promote Innovative Environments	✓
	7. Put Digital First	✖

	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	×
	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	×
	7. Staff and Resources	×
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Welsh Health Circulars are received from Welsh Government by the Corporate Governance Team, where they are logged and then distributed to the appropriate Executive Director for action.

An overview of the position as of the 20 February 2023 is as follows:

- For those WHCs received in 2018 there are 47 Complete and 1 Partially Complete
- For those WHCs received in 2019 there are 37 Complete and 1 Partially Complete
- For those WHCs received in 2020 there are 15 Complete and 1 Partially Complete
- For those WHCs received in 2021 there are 22 Complete and 2 Partially Complete
- For those WHCs received in 2022 there are 6 Complete, 5 Partially Complete, 15 Not Yet Due and 1 No Progress.
- For those WHCs received in 2023 there is 1 Complete and 1 Not Yet Due
- For those Ministerial Directions received in 2022 there is 1 Complete and 1 Not Yet Due

Please note: WHCs 2022 017, 2022 018 and 2022 021 are not fully applicable to the services provided by the health board and have been classified as partially complete and No Progress following review by the Medical Director.

Appendix 1 provides the Committee with an overview assessment of current outstanding WHCs and Ministerial Directions, and the progress made to action them.

Appendix 2 provides the Committee with an overview of WHCs actioned since the last reporting period.

Patterson,Liz
17/03/2023 15:10:13

DETAILED BACKGROUND AND ASSESSMENT:

Previously, work has been taken forward to implement robust systems for recording and tracking WHCs from Welsh Government. The circulars were re-introduced in September 2014 to replace ministerial and health professional letters.

The Health Board has implemented a tracking tool for monitoring the status of WHCs, which reflects the tracking tool also adopted for the monitoring of audit recommendations and regulatory reviews and inspections.

The table below provides the Audit, Risk and Assurance Committee with an overview of the Welsh Health Circluars and Ministerial Directions that remain outstanding with No progress made. The Committee is asked to discuss the current position of the one outstanding WHC.

WHC/MD Ref	Welsh Health Circular	Executive Lead	Status
2022 017	Wales Rare Diseases Action plan 2022-2026	Medical Director	No Progress

The following table provides an overview of the progress made against the implementation of WHCs received in 2018, 2019, 2020, 2021, and 2022. The table also provides an update on the progress made against WHCs received in the 2023 year to date.

	2018	2019	2020	2021	2022	2023
Not Yet Due	0	0	0	0	15	1
No Progress	0	0	0	0	1	0
Partially Complete	1	1	1	2	5	0
Complete	47	37	15	22	6	1
TOTAL NUMBER ISSUED	**48**	**38**	**16**	**24**	**27**	**2**

NEXT STEPS:

The Corporate Governance Team will continue to log and distributable Welsh Health Circulars and Ministerial Directions from Welsh Government to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported to the Audit, Risk and Assurance Committee on a bi-annual basis, the next update report is due to be presented on 10th October 2023.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2022 017	Wales Rare Diseases Action plan 2022-2026	16/06/2022	Health boards and NHS trusts, where appropriate, are asked to work with Welsh Health Specialised Services Committee (WHSSC), Rare Disease Implementation Group (RDIG), third sector and other relevant organisations to facilitate and implement the priorities and actions outlined in the Wales Rare Disease Action Plan. Health boards should take account of the priorities for rare diseases when planning their services and developing their Integrated Medium-Term Plans (IMTPs).	Medical Director	Ongoing	No Progress	February 2023 Update remains unchanged from October 2022. We are hoping to ensure representation via the specialised service lead but this post is currently not yet in place. October 2022 Update PTHB does not provide any specialised services. It does not have the range of Clinical Directorates that would usually be involved in supporting and implementing this work in relation to Rare Diseases. The Planning and Performance Directorate attends the WHSSC Management Committee and the CEO attends the WHSSC Joint Committee. Through participation in the WHSSC Management Group and Joint Committee PTHB works to ensure that its Integrated Medium Term Plan reflects the approved WHSSC Integrated Commissioning Plan. PTHB does not have the capacity to take forward this work in a more detailed way. The health board is attempting to create a Specialised Pathway Lead post.	2022-017 - Wales e Diseases Action
2018-022	Sharing Patient information between healthcare professionals – a joint statement from the Royal College of Ophthalmologists and College of Optometrists	03/09/2018	To note that on 20 March 2015 the Royal College of Ophthalmologists and the College of Optometrists issued a joint statement encouraging ophthalmologists to share clinical information with the referring optometrist. To ensure hospital policies and procedures encourage this communication so that it becomes standard practice for planned and unplanned ophthalmology care in Wales.	Medical Director		Partially Complete	February 2023 For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout Due to national system delays implementation date will not take place until Q1 2023/24. PTHB readiness was completed in May 2022 March 2022 For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout 22/23. Clarification of the current situation was sought from localities in September 2018. The north Powys locality confirms the destination of clinic letters is instructed by the consultant. Sending information back to the referrer (as well as the patient's GP) is inconsistent. The locality has agreed to draw the consultants' attention to the requirements of the new WHC. A response from the mid/south Powys locality is still being pursued. Update - The joint statement clarified best practice as writing to the referring optometrist as well as the GP. We can ensure that that is being done in Powys hospitals, but providers out of the county will have their own policies, hence I expect that the picture across Powys is variable. With the new EPR optometrists will be able to look at eye care records for their own patients, including clinic letters, so this will become moot. Of course this will not apply to our English providers.	022- Sharing Patient Information - Royal College of
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery Meetings.	Medical Director		Partially Complete	February 2023 ALSO REPORTED UNDER DON Antimicrobial stewardship group established, meets quarterly and feeds into the IPC Group. Antimicrobial stewardship improvement plan in place. Primary care antimicrobial prescribing monitored monthly against a number of KPIs. Practices provided with KPI performance reports on a monthly basis. Antimicrobial stewardship discussed at all practice meetings and relevant targets included in the prescribing incentive scheme and relevant SLAs. Start Smart Then Focus (SSTF) undertaken by the Community Services Medicines Management Team. MicroGuide implemented to improve access to antimicrobial prescribing guidelines. October 2022 Update HCAI 2021/22 Full Year reduction expectations have all been met. C. difficile: Rate of 25 per 100,000 - Achieved S. aureus bacteraemia: Rate of 20 per 1000,000 population - Achieved E. coli bacteraemia: Rate of 67 per 1000,000 population - Achieved Klebsiella sp. Bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved P. aeruginosa bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved 8 years since last MRSA bacteraemia. March 2022 See also 2021/028 AMR & HCAI Improvement Goals For 2021-22 for more detailed update 5 year National Action Plan 2019 – 2024 underpinning the UK AMR Strategy 20: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024	019 - HCAI AMR Targets 2019-20 FINAL.pdf
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Medical Director	Immediate	Partially Complete	February 2023 Survey of PTHB services to understand PROMs and PREMs already in use completed. Links made with Welsh Value in Health Centre (WViHC) to national work and contact made with English Integrated Care Systems to discuss PROMs and PREMs for Powys patients treated in England. Discussion with WViHC and DHCW about PROMs for Powys patients treated in other Welsh health boards and in English NHS Trusts suggests dataflows should allow this (may require DHCW approaching NHS Digital). February 2023 PTHB has continued to raise the importance of nationally developed dashboards including commissioner views and including English data for Welsh patients treated over the border to ensure that health boards can understand outcomes, cost and experience for all of their resident populations. Some of the recently launched, nationally developed dashboards, continue to be provider-focussed and/or do not include English data. PTHB colleagues are working with DHCW to address these issues. October 2022 Update. Survey of PTHB services to understand PROMs and PREMs already in use completed. Links made with Welsh Value in Health Centre (WViHC) to national work and contact made with English Integrated Care Systems to discuss PROMs and PREMs for Powys patients treated in England. Discussion with WViHC and DHCW about PROMs for Powys patients treated in other Welsh health boards and in English NHS Trusts suggests dataflows should allow this (may require DHCW approaching NHS Digital). A paper outlining an organisational approach to generic PROMs will be considered by PTHB Transformation & Value Group Executive Committee on 09/11/22. Work is underway in Powys in relation to: •Diabetes •Frailty •Eye Care (Cataracts) •Cancer •MSK (Orthopaedics) PTHB has continued to raise the importance of nationally developed dashboards including commissioner views and including English data for Welsh patients treated over the border to ensure that health boards can understand outcomes, cost and experience for all of their resident populations.	003 - Value Based Health Care Programme - Data
2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to provide updates at three monthly intervals from April 2021. Health Boards will be aware that there are two cohorts of children that will need "mopping up" due to the Covid-19 pandemic, communication of how this will be managed will follow with the "Standard Operating Procedure" and related documentation.	Director of Primary, Community Care and Mental Health	30/07/2022	Partially Complete	16.02.2023 Screening remains with the SN Services and no new update has been received from Audiology Services. 17/10/2022 progress continues with communications between audiology and school nurses, screening remains with SNs. Led by the PTHB Head of Audiology, in conjunction with School Nursing service with Powys, this has already progressed some key elements. Expectation of quarterly updates prior to full implementation no later than April 2022.17.06.2022 - Discussions ongoing, Head of Audiology leading, SBAR completed by Head of Audiology with Standard Operating Procedure also in process of being completed by service. Audiology requesting screening remains with School H7 Nursing with their oversight. Discussions planned between Audiology and School Nursing in coming weeks with a view to completing implementation September 2022. School Nursing services have undertaken 'mop up' of outstanding cohorts and programme will be up to date by end July 2022.	J:\ Services\Risk & As
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Partially Complete	Feb 2023: PTHB Carpal Tunnel Pathway under review with support from Hand & Wrist surgeon from Robert Jones Agnes Hunt NHS Trust who undertake largest volume of commissioned CTS procedures. Incorporating GIRFT/BHSS and WHC pathways into review. Anticipated pathway review completion end March 2023 including engagement with stakeholders across the pathway including, primary care, provider and commissioned services October 2022 Update Followed up with National AHP rep for WOB - other HBs still following existing pathways and no progression of discussions nationally to date. Decision to be made locally whether primary care position has now changed to facilitate implementation of the WOB endorsed CHS pathway in Powys, this could be facilitated through the changes arising from the Accelerated Cluster Development structure. June 2022 Update Still awaiting national discussion. March 2022 Update. Following submission of a development plan for this WHC, an implementation group was formed. Concerns were raised regarding the ability to embed the assessment measure advised within the WHC into primary care at such a busy time operationally and advice was sought from other HBs MSK leads to determine how this was being managed across Wales. Feed back was that there were concerns regarding the pathway and its implementation from most HBs and the AHP representative on the Welsh Orthopaedic Board agreed to take this back to the Board for discussion. Unfortunately, the meeting scheduled for February was postponed to March and has again been postponed to May meaning that it has not yet been discussed. Therefore whilst we have a development plan in place for this WHC, implementation has been paused whilst we await discussion at the WOB in relation to the national feed back.	J:\ Services\Risk & As
2022 004	Guidance for the care of children and young people with continence problems	21/10/2022	The All Wales Continence Forum have undertaken work to review the All Wales Children and Young People's Continence Guidance and Care Pathway and have recommended that the current guidance should be replaced with the newly published 'Guidance for the provision of continence containment products to children and young people' (2021) thereby removing the discrepancy in the original guidance.	Director of Nursing and Midwifery	31/10/2022	Partially Complete	The service is completing the SOP which will incorporate the guidance – the deadline for completion has overrun but is expected for completion this quarter. The review of the list of the children in receipt of containment products against the guidance is outstanding this has been requested again as a priority for completion this quarter.	WHC 2022 004 - iatric continence (WHC 2022 ovision of contine
2022-007	Recording of Dementia READ codes	15/02/2022	Annex 1 sets out the READ codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their carer (if they wish to receive this information), and within the Memory Assessment Service, Learning Disability Memory Assessment Service and primary care data bases. It also sets out guidance for Welsh Health Boards to assist with the recoding of a diagnosis of dementia using the READ CODES.	Director of Primary, Community Care and Mental Health	30/07/2022	Partially Complete	28.03.22 Circular shared with General Practice. GP already familiar with the READ codes as need to be caputured for QAIF. READ coded dementia registers in place. 30.03.22 The READ codes are included in the Dementia Care Pathway of Standards. The Dementia Lead is working with Improvement Cymru and PTHB MAS teams to ensure READ codes are captured on all correspondence to GP's and copy letters to families in order to capture Powys dementia diagnostic rates. This needs to be in place in order to reflect realistic diagnostic rates. Historically READ codes have not been used on the correspondence but currently work is underway with MAS admin, nurses and consultants to ensure this does happen going forward. 17.06.2022 medical secretaries have confirmed that they are using the new read codes. PTHB has asked to add some other codes too, as sometimes the doctors give a 'probable' diagnosis, Dementia Lead investigating, updated expected July 2022.	WHC 2022 007 - READ codes

2022 018	Guidelines for managing patients on the suspected cancer pathway	30/06/2022	The achievement of the cancer target is the responsibility of NHS Wales as set out in the quality statement for cancer. The underlying principle of the suspected cancer pathway is that patients should receive excellent care without delay. This document sets out the rules to ensure that each patient's pathway waiting time is consistent and unnecessary delay does not occur as patients pass between clinical teams and organisations.	Medical Director	Immediate	Partially Complete	February 2023 PTHB provides limited diagnostic services for cancer and minimal treatments. The majority of Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. Referral to treatment times are the responsibility of the Director of Planning and Performance for Commissioned Services and the Director of Primary, Community Care and Mental Health for directly provided services. Performance is monitored through the Integrated Performance Framework for the health board and regularly reported to the Board and relevant committees. The Cancer Renewal Programme has established a Harm Review Panel to review harm reviews undertaken by other health boards and NHS trusts treating Powys patients. October 2022 Update PTHB provides limited diagnostic services for cancer and does not provide any cancer treatments. Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. The Cancer Renewal Programme has established a Harm Review Panel to review on breach reports and pathway reviews completed by Commissioned Providers to identify factors causing delays to inform future planning of services and commissioning to follow up. A Cancer Tracker role has been created as part of this process. PTHB is also developing a Power BI Tool to enable live tracking of Powys residents on urgent suspected cancer pathways to identify patients who are at risk of breaching and who are breaching target waiting times to enable intervention. This process is in development.	2022- 018 nes-for-managing
2022 006	Direct Paramedic referral to same day emergency care	21/04/2022	In order to reflect local service models, each health board will need to agree with WAST the mechanisms for enabling the 'clinician to clinician' discussion, which forms the basis of the acceptance of patients into SDEC services.	Director of Primary, Community Care and Mental Health	Immediate	Partially Complete	17/02/2023 Emergency/acute care not commissioned within Powys. However, a range of actions being taken as defined in the Integrated Care ACtion Plan (ICAP), fully integrated with 6 Goals delivery and reviewed in montly monitoring arrangements. tOngoing work with commissioned partners to ensure quality, safe and timely care in Emergency Departments – annual cycle, alongside daily engagement with operational flow across National urgent care sustem.	2022-006-Direct-p nedic-referral-to-s
2022 021	National Optimal Pathways for Cancer	28/07/2022	The Quality Statement for Cancer requires that the nationally optimised pathways are fully embedded in local service delivery. They are designed to reduce unwarranted variation in care delivery across Wales and to help organisations to plan to meet the Suspected Cancer Pathway waiting time target. Executive Board note and discuss the pathways as part of the implementation of the Suspected Cancer Pathway. Executive leads for cancer use the pathways to support the planning, delivery, and performance monitoring of cancer services. Directors of Planning incorporate the pathways into their planning assumptions. Site specific local, regional and national MDTs to adopt the pathwaysor justify reasons for variations.	Medical Director	30/09/2022	Partially Complete	February 2023 PTHB provides limited diagnostic services for cancer and minimal treatment. The majority of Powys residents with suspected cancer are managed by commissioned NHS services. In the Powys context the optimal pathways apply across organisational boundaries involving services provided by other health boards in Wales and also services provided by NHS trusts in England. Executive leads for cancer need to use the optimal pathways to support planning and design of pathways. The Wales Cancer Network has appointed two posts managed centrally to work with PTHB on mapping the optimal pathways. However the first stage produced highly generalised information which was of limited value. At present only the Welsh flows are included but to be meaningful for Powys this must also included it's English flows so further work is being undertaken with the network. October 2022 Update PTHB provides limited diagnostic services for cancer and does not provide any cancer treatments. Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. PTHB has established a Harm Review process to review breach reports produced by the commissioned providers. PTHB is engaging with the Wales Cancer Network (WCN) programme to review USC pathways for Powys residents. The Improving the Cancer Journey (ICJ) Programme in Powys is offering eHNAs to people diagnosed with cancer to provide support and facilitate accessing local resources to meet their needs. The PTHB Advice, Support and Prehabilitation Programme are exploring Prehabilitation in collaboration with the ICJ Programme for people living with cancer in Powys.	WHC_2022_021 - onal Optimal Pathv
2022-005	Data Requirements for Value Based Health Care	24/03/2022	The basis of the WHC and subsequent processing of information is made in consideration of: Section 1 of the National Health Service (Wales) Act 2006 which places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales, and in the prevention, diagnosis and treatment of illness. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty. Pursuant to Section 3 of the National Health Service (Wales) Act 2006 the Welsh Ministers have a statutory duty to, inter alia, provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements, healthcare services and such other services or facilities as they require for the diagnosis and treatment of illness. Pursuant to Section 12 of the National Health Service (Wales) Act 2006, the Welsh Ministers may direct a Local Health Board to exercise in relation to its area functions relating to the health service. Pursuant to the Local Health Board (Directed Functions) (Wales) Regulations 2009, the duty under Section 3 of the 2006 Act has been delegated to the Local Health Boards and are thus responsible	Director of Finance and IT, Medical Director and Director of Primary, Community Care and Mental Health	31/03/2025	Not Yet Due	February 2023 Powys continues to participate in the small number of National Clinical Audits and Outcome reviews where it offers a relevant service. These are; National Diabetes Foot Care Audit, All Wales Audiology Audit, Sentinel Stroke National Audit Programme, National Audit of Care at the End of Life, National Confidential Inquiry into Suicide and Safety in Mental Health, Maternal, Newborn and Infant clinical Outcome Review (MBRRACE) CIVICA continues to be rolled out for PREMs collection in Powys. On 09/11/22 PTHB Executive Committee approved the use of EQ-5D-5L as the 'generic' organisational PROM, with condition specific PROMs 'layered' on top. A PROMs Implementation Task & Finish Group has been established to consider the options for the deployment of an organisational approach to PROMs for PTHB. This work will also align to the All Wales Outcome Framework being developed by the Welsh Value in Health Centre. The national group is also currently undertaking the 'quality' assessment of the tenders, then will move to financial analysis. Oct 2022 Action on going to develop PROM and PREM data within the Health Board and to ensure aligned to WHC requirements, also linking in with Value in Health to align to national approach re PROM and PREM. Agreement from VBHC Programme Board on 24.05.2022 to link and track through VBHC Programme Plan.	WHC 2022 005 requirements for V WHC 2022 005 - requirements for
2022-010	Reimbursable vaccines and eligible cohorts for the 2022/23 NHS seasonal Influenza (flu) Vaccination Programme	29/03/2022	General practices, community pharmacies and health boards/trusts should review influenza vaccine orders in light of this update to attain levels of uptake at least equivalent to those achieved in 2021-22. There may be further policy developments to support maximum uptake across all eligible cohorts during 2022-23. Further advice will be communicated as soon as possible in the Chief Medical Officer's annual influenza letter, which will be issued in the summer.	Director of Public Health	01/03/2023	Not Yet Due	Update 16/02/23: -Letter 11/10/22 to all GP Practices/Pharmacies sent from DPH through pharmacy and Primary care lead– -Email from primary care to all GP Practices re suitable vaccines for different age cohorts sent 07/10/22 -Email from Chief Pharmacist to all Pharmacies re suitable vaccines for different age cohorts sent week of 03/10/22 -Regular 'flu' vaccination meetings with primary care reps led by Consultant in Public Health -Regular public comms/digital/social media, include press release. - Walk-in offer to eligible public to attend MVCs for flu vaccine from beginning of January 2023. 17/10/22:- Regular PTHB Influenza Vaccination Oversight Group held, led by Consultant in Public Health, with GP Practice reps. GP and Community pharmacies commissioned to deliver flu vaccine. Correspondence from pharmacy team and Primary care team to community pharamcies and GP Practices week of 03/10/2022 to remind to administer correct vaccine to eligible groups and to inform HB of any errors.	WHC_2022_010 - bursable vaccines
2022-009	Prioritisation of COVID-19 patient episodes by NHS Wales Clinical Coding Departments	14/04/2022	Due to the need for COVID-19 information to be as real-time as possible all NHS Wales Clinical Coding departments are asked to ensure that processes are put in place as soon as possible to ensure the following: All FCEs for patients with COVID-19 are identified upon discharge and prioritised by the Local Health Board/NHS Trust for the assignment of codes Such episodes of care are coded within the first week following discharge to allow for an accurate view of COVID-19 inpatient data on a weekly basis Each Local Health Board and NHS Trust to report their current numbers and percentages of uncoded COVID-19 and non COVID-19 episodes to Welsh Government (HSS.Performance@gov.wales) on the last day of each month	Director of Finance and IT	28/02/2023	Not Yet Due		WHC 2022 009 - vid 19 Priority Clini
2022-016	The National Influenza Vaccination Programme 2022-23	01/06/2022	Health Boards are asked to take a strategic approach to identify and exploit opportunities for a single programme, including co -administration of Flu and COVID-19 vaccines. This may entail taking key operational decisions, such as ensuring supplies of flu and COVID-19 vaccine are available for co-administration in suitable settings. It is likely that co-administering both the vaccines at the same time will go some way to increase flu vaccine uptake, to a level commensurate with COVID-19 take-up, particularly for younger at risk groups. Flu at risk cohorts have been expanded for 2022-23 to more closely align with COVID at risk groups and maximise opportunities for co-administration.	Director of Public Health	31/03/2023	Not Yet Due	update 17/10/22:- Regular PTHB Influenza Vaccination Oversight Group held, led by Consultant in Public Health, with GP Practice reps. All GP Practices and Community Pharmacies participating in flu vaccination programme. All GP Practices invited to participate in the Autumn covid-19 vaccination programme. 12 out of 16 GP practices agreed to participate in covid-19 campaign: 11 GP Practices offering covid-19 vaccine to over 75s cohort and COPD cohort, 1 GP Practice offeriing to all eligible groups (bar Health & social care staff/care home residents). Delivery of remaining coivd-19 to eligbile groups via HB MVC/Mobile teams. Co-administering flu and covid vaccination to health board staff. Meetings held with individual GP Practices in late August/early September to discuss COVID-19 programme delivery and confirmation letter sent to each individual practice outlining programme expectations and support available.	WHC2022-016 - National Influenza
1MD	Our programme for transforming and modernising planned care and reducing waiting lists in Wales	26/04/2022	This plan sets out a number of clear priorities for action over the next four years. They focus on immediate actions to release capacity to enable the NHS to see and treat more people and some slightly longer-term actions which will continue to transform the service, in line with the vision set out in A Healthier Wales.	Director of Primary, Community Care and Mental Health	Apr-26	Not Yet Due		MD1. ng and Modernisi
2022-019	Non Specialised Paediatric Orthopaedic Services	21/06/2022	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales.	Director of Primary, Community Care and Mental Health and Senior Manager Planned Care	01/04/2025	Not Yet Due		WHC 2022 019 - Specialised Paedi
2022-012	Donation and Transplantation Plan for Wales 2022-2026	16/06/2022	Health Boards and NHS Trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation. Advisory Group (WTAG), third sector and other relevant organisations towards implementing the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their Integrated Medium Term Plans (IMTPs).	Medical Director	31/12/2026	Not Yet Due		2022- tion-and-transplar

2022 022	Role of the Community Dental Service and Services for vulnerable people	22/08/2022	Health boards should use their professional advisory structures to review and inform the provision of dental care by all local dental services including the CDS, primary care services provided by General Dental Services (GDS), Personal Dental Services (PDS) and Hospital Dental Services (HDS), and how these relate to local authority boundaries and primary care clusters. Specialists and Consultants in Dental Public Health will provide detailed and expert assistance in needs assessment and in collaboration with others, advice on service development. The Community Dental Service should be regarded as an integrated dental service with a diverse and flexible role. It should not be regarded as a purely primary care-based service. A strong community dental service will provide all services needed for its local population and this can include both consultant, specialist, intermediate and routine general dental services. The Community Dental Service should be encouraged to work in collaboration with local hospital based dental services including oral and maxillofacial services. An effective CDS will require investment in both workforce and infrastructure, ensuring that the clinicians have access to modern equipment and robust IT systems. Poor infrastructure is seen as a barrier to recruitment and retention of staff.	Director of Primary, Community Care and Mental Health	01/08/2024	Not Yet Due	Recruited 1 WTE salaried GDP to provide routine GDS services, o.6WTE vacancy for specialist in special care dentisty. Looking to use a cloud based service to imporve IT record systems within the CDS. Recruitment of paeditatric specialist for 3 sessions per month to improve governance and service. Skill mixing using direct access therapists	WHC 2022 022 - tole of the Commu
2022 023	Changes to the vaccine for the HPV immunisation programme	09/09/2022	Change to the vaccine schedule The Gardasil®9 vaccine will be provided for the following schedules of the HPV programme: • a one-dose schedule for the routine adolescent programme and MSM programme before the 25th birthday • a 2-dose schedule from the age of 25 in the MSM programme • a 3-dose schedule for individuals who are immunosuppressed and those known to be HIV-positive The UK Health Security Agency will continue to supply vaccine for the HPV programme in the usual way. It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year. Until the one dose schedule commences, the current 2 dose schedule will remain in place. Further communications will be issued once decisions have been made on the timing of the changes.	Director of Public Health	30/09/2024	Not Yet Due	Update 17/10/2022: email sent 13/09/2022 from DPH to school health nursing (immunsation service leads)and Chief Pharmacist to inform of future changes and to action. Confirmation received from chief pharmacist is aware for PGD changes. No further action to take currently as the WHC states: 'It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year'.	2022_023-WHC-H hunisation Prograr
2022 003	Guidance for the provision of continence containment products for Adults in Wales	21/10/2022	This document aims to outline national guidance to prevent variation and discrepancy in provision of containment products. It states that personalised care planning is a fundamental activity guiding best practice for the provision of containment products for adults in Wales. This is essential prior to identifying management options and consideration of the use of containment products. There is no statutory requirement to provide pad containment products if an individual does not fulfil the guidance for product provision.	Director of Nursing and Midwifery	31/10/2025	Not Yet Due	We have Band 6 Continence Promotion Practitioners. Waiting list around 8 weeks. They assess patients and from their assessment pads may or may not be provided. We are an assessment/ treatment service and pads are provided on need and according to bladder and bowel dysfunction. We have a triage system for referrals so end of life patients for example are assessed and pads provided if required within 48 /72 hours. For children, the appropriate person assesses, e.g. children's nurse, school nurse etc and pads are then allocated again according to need.	WHC 2022 003 t continence prod WHC 2022 003b Continenece Guid
2022 027 2022 029	Urgent polio catch-up programme for children under 5 years old	24/10/2022	To minimise the risk posed by the current incident, where surveillance has found a type 2 vaccine-derived Polio virus (known as VDPV2) in sewage samples taken from north London and recent decreases in vaccine uptake, I feel it is imperative that we carry out a 'targeted' immunisation catch-up programme across Wales. Consequently, I would like health boards to commence such a programme targeting children under 5 with partial or no vaccination against Polio without delay, It will be a matter for each health board to decide how they wish to complete this exercise. However, we recommend engaging with primary care services and/or others such as health visitors, midwives and school nurses, in order to take this forward as soon as possible. A new National Enhanced Service (NES) specification is being put in place to facilitate delivery of this, and any future, immunisation catch up programmes.	Director of Public Health	31/03/2023	Not Yet Due	Update 16/02/23: DPH Email to Primary care Team to ask them to send letter to GP Practices to ask who wishes to participate in catch-up, with deadline of 09 Nov 22 for returns. All GP Practices participating in catch-up and underway.	WHC 2022 027 - sh Health Circular WHC 2022 029 - o catchup 2022 - f
2022 026	Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning	11/10/2022	The approach outlined focuses on the measures we will take when operating in a Covid Stable environment, whereby we expect further waves of infection but that we do not expect these to put continued unsustainable pressure on the Health and Social Care system. We have in the last couple of weeks, here and across the UK, seen an increase in infections in the community and in the number of people admitted to hospital. I am therefore seeking your support in the following areas: • Our best line of defence is vaccination and it is essential we provide access and support for health and care workers to take up their vaccination offers for COVID-19 and influenza - I am therefore asking for a commitment that all clinical leads have a conversation with each member of their team regarding their vaccination intentions in the next two weeks. • The importance of educating staff on the continued importance of good personal hygiene and staying away from work if they have symptoms, taking a test and following the advice. • That mask wearing is encouraged with staff and visitors in our hospitals including public areas.	Director of Public Health	01/10/2023	Not Yet Due	Update 16/02/23: Letter 11 October 2022 from DPH to all GP Practices/Pharmacies (sent via pharmacy and Primary care leads). Agenda item on Executive Committee meeting on 19 October 2022. Letter to all HB staff inviting for co-administering covid=19 & flu vaccinations commending week of 10/10/22. Joint Message to all staff from 4 Executive clinical leads to encourage vaccination & how to access covid & flu vaccines (communicated via Powys News and carousel) (live on carousel from 26/10/22) . CEO include message on vaccination in all staff briefing on 26 October 2022. -Pathway and triage processes in place, led by pharmacy, to access antivirals. Pathway reviewed regularly jointly by Chief Pharmacist, MD, DPH & AD Community Services. Testing pathways in place-12/10/2022 WHC Shared with IP&C team on and asked for the actions required to be considered and reviewed at Infection, Prevention and Advisory Group meeting held on 13/10/22, resulting in guidance re protective measures being updated (i.e. extended mask wearing to all clinical areas) to protect patients, staff and visitors, with communication cascaded to staff. Guidance continually reviewed and adapted throughout the Winter period.	WHC 2022 026 - hcare Technical Do
2022 013	Monthly Financial Monitoring Return Gudiance	26/04/2022	This guidance refers to the monitoring return spreadsheet and accompanying narrative that all organisations (Local Health Boards (LHBs), Special Health Authorities (SHAs) and Trusts) will need to complete, to report their 2022/23 financial performance. There are a number of changes to the format of the returns from those issued previously. Colleagues are asked to review this guidance in full to refresh and confirm their understanding.	Director of Finance and IT	01/04/2023	Not Yet Due	The Health Board is meeting WG guidance in respect of reporting its financial performance to WG.	WHC 2022 nthly-financial-mo
2022 008	New records management code of practice for health and care 2022	01/07/2022	The purpose of this Welsh Health Circular is to notify all organisations working within the NHS in Wales (i.e. NHS Trusts, Local Health Boards and Special Health Authorities), and those organisations working under a contract with the NHS and create records (e.g. primary care providers, secondary care services such as scanning services, laboratory services and agencies) as well as local authorities in Wales who commission or deliver adult social care and public health functions of the publication of a new updated Records Management Code of Practice for Health and Care 2022.	Director of Finance and IT	01/05/2023	Not Yet Due		WHC 2022 008 cords managemer
2022 031	Reimbursable vaccines and eligible cohorts for the 2023/24 NHS Seasonal Influenza (flu) Vaccination Programme	08/12/2022	Uptake of flu vaccines should be maximised in eligible groups again in 2023-24, as we anticipate COVID-19 and flu will continue to co-circulate next winter as social mixing continues to return to pre-pandemic levels. Achieving a high uptake of both vaccines is vital to reduce morbidity and mortality associated with both viruses, and to reduce hospitalisations during a time when the NHS and social care are most under pressure.	Director of Public Health	30/03/2023	Not Yet Due	Update 16/02/23: – Email from DPH on 09/12/22 to Jacqui Seaton (Pharmacy Lead), Jayne Lawrence (Primary care lead) Berndatte /Mary Cottrel (school nursing), and chair of imms group. Askes Jacqui and Jayne to send on to GP Practices and community pharmacy and for ordering of HB stocks.Further email on 13/12/2022 – Email sent to Jayne L/Jaqui Seatton to disseminate update guidace received to community pharmacy & GPs. Additional actions as per flu update above.	WHC 2022-031 - bursable vaccines

2022/035	Influenza (flu) Vaccination Programme deployment 'mop up' 2022-2023	22/12/2022	Health Boards are asked to support Primary Care services witht the flu 'mop up' work from January 2023, through health board vaccine centres. Health boards, working in collaboration with Primary Care teams, are asked to draw up detailed plans on how the flu vaccination 'mop-up' exercise will operate. These plans, once finalised, will need to be shared with the NHS Wales Delivery Unit, for the purposes of supply management. Health boards will also need to communicate a clear message to their local populations as to how, when and where individuals are able to obtain vaccination in that area. A weekly summary of administered vaccinations will be provided by health boards to the registered GPs of vaccinated individuals, which will require administrative work within practices.	Director of Public Health	30/03/2023	Not Yet Due	Update 16/02/23. Email sent on 23/02/23 to vaccination team to action circular. Walkins in place from early January for all eligible residents at all 3 MVCs. Promoted at aleast weekly through HB comms channels. Proactive MECC approach to all eligible attendees attending for COVID-19 vaccination.	WHC 2022 035 - uenza (flu) Vaccina
2023/001	Eliminating hepatitis (B and C) as a public health threat in Wales – Actions for 2022-23 and 2023-24	12/01/2023	Welsh Government has established a Hepatitis B and C Elimination Programme Oversight Group. First meeting of this group was held on 15th November 2022 and a refreshed roadmap for elimination has been agreed as set out within this circular. Circular requested for atttention to be drawn to the 13 action points which the group will be monitoring. The circular advised it looks forward to support and working with the group to ultimately eliminate heatitis B and C as a public health threat by 2030 at the latest. A further circular updating on progress will be issued in 2023 (no specific date specified).	Director of Public Health	31/03/2023	Not Yet Due	Update 16/02/23 - email sent to Medical Dir/Nurse Dir/Pharmacy Lead/Mental Health Lead/Commissioning Lead for actions which fall within their areas.	

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2022-014	AMR & HCAI IMPROVEMENT GOALS FOR 2021-23	01/03/2022	Wales remains committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action PlUK AMR Strategy an 2019-24 to combat antimicrobial resistance, through lowering the burden of infections, improving treatments and optimising our use of antimicrobials in humans.. National Action Plan ambitions are shown in highlighted boxes as applicable to each improvement goal.	Director of Nursing and Midwifery	31/03/2023	Complete	Antimicrobial stewardship group established, meets quarterly and feeds into the IPC Group.Antimicrobial stewardship improvement plan in place.Primary care antimicrobial prescribing monitored monthly against a number of KPIs. Practices provided with KPI performance reports on a monthly basis. Antimicrobial stewradship discussed at all practice meetings and relevant targets included in the prescribing incentive scheme and relevant SLAs.Start Smart Then Focus (SSTF) undertaken by the Community Services Medicines Management Team. MicroGuide implemented to improve access to antimicrobial prescribing guidelines. PTHB have the ambition in 23/24 to achieve bronze level accreditation from the Association of Safe Aseptic Practice for compliance with aseptic non-touch technique. This will be realised by demonstrating our commitment to aseptic practice through education and training, assessment, audit and policy.	WHC_2022_14 - CAI Improvement
2022-002	NHS Wales National Clinical Audit and Outcome Review Plan. Annual Rolling Programme for 2022-2023	10/06/2022	Health boards, trusts and relevant special health authorities in Wales are required to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: The Plan details the role each of us has for taking this work forward and includes the list of National Clinical Audits and Outcome Reviews, which all healthcare organisations must fully participate in when they provide the service.	Medical Director, Directors of Primary, Community Care and Mental Health and Director of Therapies and Health Science	01/04/2023	Complete	February 2023 complete but with acknowledgement that participation in audits will be improved in 23/24: The Podiatry service is participating in the National Diabetes Foot Care audit and the collection of data for the audit is on-going. An action plan will be published following the release of the national report. 17/02/2023 National Diabetes Foot Care Audit: The Powys Teaching Health Board (PTHB) Podiatry service are participating in the audit this year, and use an audit form to record all foot wounds on patients with diabetes. The data is shared and published nationally. The service is also learning from best practice in other areas and areas with similar demographics, whilst tracking progress across years and benchmarking against neighbouring health board areas. Major Trauma Audit (Trauma Audit and Research Network (TARN)): PTHB participates in the Major Trauma Network Audit - via the South Wales Major Trauma Network (SWMTN). All data is captured and entered in the acute pathway and entered by clinicians and administrators working in acute sites within the network to the TARN database. No PTHB clinicians enter data. TARN data is reported via the South Wales Trauma Network Governance Group on a quarterly basis. PTHB utilised TARN data to inform the SWMTN Peer review process in April 2022 and also feeds back via NC&S Steering Group. Implementation of learning and improvement from the audit is reported through PTHB Stroke and Neurological Conditions Steering Group, which meets quarterly. Sentinel Stroke National Audit Programme (SSNAP): PTHB participates on the non-acute inpatient rehabilitation and six month review sections of SSNAP. Data is collected by clinicians on the two inpatient stroke wards and by clinicians delivering six month reviews and entered either by them directly or by the Community Neuro Service Coordinator from a paper record. The Information Team have developed a dashboard in the Information Focused On-line Reporting	WHC2022 002 - onal Clinical Audit
2022 020	Never Events Policy and Incident list	22/07/2022	As with all patient safety incident reporting NHS organisations must assure their Boards that Never Events have been investigated appropriately, in line with the national reporting policy and appropriate actions taken with any lessons learnt shared throughout the organisation to help reduce the risk of similar Never Events happening again. Robust monitoring processes should be in place to support implementation and delivery of agreed actions and to ensure sustainability of those actions going forward. As part of quality assurance processes the NHS Wales Delivery Unit will monitor and review all Never Events, including lessons learnt and the timely implementation of corrective actions. Where appropriate the NHS Wales Delivery Unit will engage with individual organisations to provide support and, or escalate any unresolved matters through existing escalation frameworks.	Director of Nursing and Midwifery	Immediate	Complete	Never Events are reported to PEQS Committee on a quarterly basis; to note there have not been any Never Events in the last 18months.	WHC-2022-020-n -events-policy-july
2022 028	More than just words Welsh Language Awareness Course	10/11/2022	One of the actions in the More than just words plan is that all NHS and social care colleagues undertake a language awareness course which will explain how important the Welsh language is in the delivery of services and to patient needs. The course should take no longer than 30 minutes to complete and includes background / context to the Welsh language, the importance of the Welsh language to the patient experience and a section on the Welsh language standards.The course is accessible via the Electonic Staff Record (ESR) system and Learning@Wales platforms. It is mandatory for all NHS staff (including those who don't deal directly with patients / service users) and it will need to be retaken every 3 years. It should be introduced as part of the induction process for new employees who have not already undertaken the training. Completion rates will be collated by NHS Shared Services Partnership with data reported to the Advisory Board to be established by the Minister to oversee the delivery of More than just words. In acknowledgement of the current pressures and the need to focus on delivery we will not start reporting this until March next year and the deadline for completion will be June 2023.	Director of Workforce and OD	30/06/2023	Complete	The Welsh Awareness Training Course is now included within statutory and mandatory training through ESR. Compliance will be monitored through the workforce performance reporting alongside all other statutory and mandatory training, Compliance as at 17.2.23 is 60.93%	WHC 2022 028 - e than just words W
2023/002	New Lower Gastrointestinal 'FIT' National Optimal Pathway	30/01/2023	Health Boards and trusts are required to move to adopt the updated Lower Gastrointestinal 'FIT' National Optimal Pathway. The new pathway will help to ensure patients on the lower GI pathway are diagnosed promptly by using our available colonoscopy capacity in the most effective way	Medical Director	21/04/2023	Complete	February 2023 ACTIONS COMPLETE All general practices now have access to symptomatic Faecal Immunochemical Test (FIT) services where there is a suspicion of colorectal cancer. The new Lower Gastrointestinal 'FIT' National Optimal Pathway documentation has been distributed to Powys General Practices. The PTHB Cancer Clinical Lead has worked closely with Cluster Leads and GP Collaboratives to ensure they are up to date with Faecal Immunochemical Test pathways and the National Optimal Pathway for FIT including highlighting the importance of 'safety netting'. An Internal Audit conducted in October 2022 concluded there was substantial assurance with regard to the controls and processes in place and that the planned actions to allow improved access to symptomatic FIT are being effectively delivered. This is now 'business as usual' with no further action required.	WHC 2023 002 er - Policy - Bowel

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.9

Audit, Risk and Assurance Committee	**Date Of Meeting: 21 March 2023**
Subject :	**BOARD MEMBERS DECLARATION OF INTERESTS 2022/23**
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Interim Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee, 8th March 2023

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with the Register of Interests for Board and Executive Members at 1st March 2023. The Board and Executive Members Register of Interests will be published on the Health Board's website.

RECOMMENDATION(S):

The Executive Committee is asked to Note the content of Register of Interest for Board Members at 1st March 2023, ahead of publication on the Health Board's website and take ASSURANCE that organisational policy is being implemented.

Ratification	Discussion	Information
✖	✖	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	×
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	×
	7. Put Digital First	×
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	×
	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	×
	7. Staff and Resources	×
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour.

The Board is strongly committed to the health board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership. In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times.

All employees and Independent Members of the Board must ensure that they are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the health board. Declarations must be made to the health board for recording in the Register of Interests any relevant interests at the commencement of employment; whenever a new interest arises; or if asked to do so at periodic intervals by the health board. The onus regarding declaration will reside with the individual employee or Independent Member.

The Register of Interests is maintained by the Corporate Governance Department. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare interests, gifts, hospitality, honoraria and sponsorship. The Register of Interests will be published on the health board's internet site.

Board Members (executive and independent) have undertaken an annual declaration exercise. The purpose of this exercise is to confirm that Board Members have read and understood the PTHB Standards of Behaviour Framework and Policy, which incorporates a duty for declaration of interests, gifts, hospitality and sponsorship. This annual declaration provides verification of any previously declared interests and gives opportunity for declarations to be updated where required.

A review of the Standards of Behaviour Policy is currently underway and will include a streamlining of current processes. Consideration is being given to using ESR for declarations of interest reporting. The review is due to be complete for the Summer 2023.

A summary of declarations received are included in the Register attached at **Appendix A**. Following consideration by the Audit, Risk & Assurance Committee the Register will be published on the Health Board's website to ensure openness and transparency.

The Director of Corporate Governance and Board Secretary has reviewed the declarations made by Board Members and can confirm that no interest declared requires consideration at this time.

NEXT STEPS:

Subject to consideration at Audit, Risk and Assurance Committee, the Register of Declaration of Interests (Board Members) for 2022/23 will be published on the PTHB website.

ACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2022/23							Updated: January 2023	
Name	**Nature of Interest**	**Nature of Declaration**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**	**Last day in Powys Teaching Health Board**
ENT MEMBERS								
Carl Cooper	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	09/11/2022	
		Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2008	16th October 2022	Recently retired as CEO of Powys Association of Voluntary Organisations (PAVO)	Salaried Employment		
	Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
		Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Apr-18	Ongoing	Employee, Swansea University	Salaried Employment		
Kirsty Williams	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2021	Current	Honory Visiting Fellow Cardiff University and Volunteer Powys Samaritans.	None	06/05/2022	
		Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	2023	Commissioner to the Constitutional review on the Future of Welsh Governance	Paid a daily rate for work undertaken		
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1987	Current	Husband is a partner in DC Rees & Son (farming business)	NIL		
Rhobert Lewis	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	NED of Green Inc Training Company Swindon	None	19/04/2022	
		Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2022	Current	Chair of governors Neath Port talbot Group of Colleges	NIL		
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Cathie Poynton	Personal	Any other connection with a voluntary,statutory,charitabe or private body that could create a potential opportunity for conflicting interests	Oct-04	Current	Staff member of Powys Teaching Health Board (a requirement to be appointed as a Independent Member to the Board for the Trade Union role)	Salaried Employment	04/04/2022	
	Spouse/Partner/Other	NIL		NIL	NIL	NIL		
Ian Phillips	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Apr-22	Current	Chair of Welsh Renal Clinical Newtwork (sub-Committee of WHSSC)	Band 3 WG sclae for Public appointments. 2 days per month	04/05/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Mark Taylor	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2013	Current	Auster Counsulting Ltd	Non NHS	12/04/2022	
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2013	Current	Auster Consulting Ltd	Non NHS		
		A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2021	Current	Son - GPHC Registered Training Position, Primary Care/CTMHB	NIL		
		A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Not Known	Current	Brother in Law (John Young) Cognomie CEO	NIL	12/07/2022	
Tony Thomas	Personal	NIL	NIL	NIL	NIL	NIL	13/04/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Ronnie Alexander	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	03/05/2022	
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Audit and Risk Committee Hafod/Hendre Housing Association	£2500.00 per annum		
	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Simon Wright	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	14/10/2022	
	Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment		
		A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2021	Current	Sister: Deputy CEO, The Advocacy Project, London	Salaried Employment		
		Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Jennifer Owen Adams	Personal						09/11/2022	
	Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2013	Present Date	Brother; senior manager for Freedom Leisure with strategic responsibility for Powys.	None		

Christopher Walsh	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	Jul-22	Present Date	Chair of Brecon University Scholarship Fund	NIL	17/11/2022	
		Any other connection with a voluntary,statutory,charitabe or private body that could create a potential opportunity for conflicting interests	May-22	Present Date	Elected Member of Powys County Council	NIL		
			1995	Present Date	Elected Member of Brecon Town Council -Chair of Finance Committee Minor Authority school Governor (Priory Church of Wales)	NIL		
			2018	Present Date	Town Council GAP Mamber on the Sustainable Development Grant Committee with BBNPA	NIL		
			1984	Present Date	Member of the Labour Party -Brecon Branch Treasurer	NIL		
			1985	Present Date	Member of the Royal College of Nursing	NIL		
			1988	Present Date	A Registered Nurse with the Nursing and Midwifery Council	NIL		
		Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	2003	Present Date	Owner of celebratory gifts/heraldic Names	NIL		
: MEMBERS								
Carol Shillabeer	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	1990	Current	Member of the Royal College of Nursing	NIL	07/04/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Jamie Marchant	Personal	NIL	NIL	NIL	NIL	NIL	05/05/2022	
	Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Current	Wife is Coporate Director of Social Services in Bridgend County Borough Council. I am not aware of any commissioning relationship with this body. There is no interaction between BCBC and my portfolio and areas of direct responsibility	Salaried Employment		
Stephen Powell	Personal	NIL	NIL	NIL	NIL	NIL	28/06/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Pete Hopgood	Personal	NIL	NIL	NIL	NIL	NIL	08/04/2022	
	Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant		
Claire Madsen	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	20/04/2022	
		Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	Salaried Employment		
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Claire Roche	Personal	NIL	NIL	NIL	NIL	NIL	06/04/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Hayley Thomas	Personal	NIL	NIL	NIL	NIL	NIL	05/04/2022	
	Spouse/Partner/Other	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	2021	Current	Husband is General Manager of Bronglais General Hospital	Not Relevant		
Kate Wright	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		04/04/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Alison Merry	Personal	NIL	NIL	NIL	NIL	NIL	05/04/2022	
	Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2022-23

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in HM Treasury's Audit and Risk Assurance Committee Handbook (March 2016), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board;
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts;
- ensure compliance with key statutory, national and best practice audit and assurance requirements and reporting arrangements.

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Governance & Assurance:								
Approach to 2022-23 Annual Accounts	DF&IT							✓
Annual Accountability Report 2021-22	BS	✓	✓					
Annual Accounts 2021-22, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit Recommendation Tracking	BS	✓		✓	✓	✓	**x**	✓
Corporate Risk Register	BS				✓	✓	**x**	✓
Losses and Special Payments Annual Report 2021-22	DF&IT		✓					
Losses and Special Payments Update report	DF&IT			✓			✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS			✓				
Review of Standing Orders	BS	✓						
Internal & Capital Audit:								
Head of Internal Audit Opinion 2021-22	HoIA	✓						
Internal Audit Progress Report 2022-23	HoIA	✓	✓	✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2022-23**						
Internal Audit Plan 2023-24	HoIA							✓
External Audit:								
External Audit Annual Report 2022	EA						**x**	✓
External Audit of Financial Statements 2021-22	EA		✓					
External Audit Plan 2022	EA							✓
External Audit Progress Report 2022-23	EA	✓	✓	✓	✓	✓	✓	✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
External Audit Review Reports	EA	In line with External Audit Plan 2022-23						
External Audit Structured Assessment	EA					✓		
Anti-Fraud Culture:								
Bribery Policy	HoLCF			✓				
Counter Fraud Annual Report 2021-22	HoLCF	✓						
Counter Fraud Update	HoLCF			✓			✓	
Counter Fraud Workplan 2023-24	HoLCF							✓
Post Payment Verification Annual Report 2021-22	PPVO		✓					
Post Payment Verification Workplan 2023-24	PPVO							✓
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2021-22	BS				✓			
Development of Committee Annual Programme of Business	BS	✓						
Review of Committee Programme of Business	BS		✓	✓	✓	✓	✓	✓
Annual Self-assessment of Committee effectiveness 2022-23	BS						**x**	✓
Committee Annual Report 2022-23	BS							✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓
Local Counter Fraud Team				✓			✓	

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Post Payment Verification Team			✓					

KEY:

BS:	Board Secretary
DF&IT:	Director of Finance and IT
HoIA:	Head of Internal Audit
HoLCF:	Head of Local Counter Fraud
EAO:	External Audit Officer
PPVO:	Post Payment Verification Officer