2023-01-31 Audit Risk and Assurance Committee

Tue 31 January 2023, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_31Jan2023 25012023.pdf (3 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *All*

1.3. Minutes of the Previous Meeting held 15 November 2022

Attached *Chair*

ARA_Item_1.3_Unconfirmed_Minutes_15Nov22.pdf (9 pages)

1.4. Matters Arising from the Previous Meeting

Oral *Chair*

1.5. Audit, Risk and Assurance Committee Action Log

Attached *Chair*

ARA_Item_1.5_Action Log_31Jan23.pdf (2 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. Application of Single Tender Waiver

To Follow *Director of Finance and IT*

ARA_Item_2.1_Application for Single Tender Waiver Jan 23.pdf (4 pages)

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Internal Audit Progress Report 2022-2023

Attached *Head of Internal Audit*

ARA_Item_3.1_Powys ARAC A&A Progress Report January 23 Cover.pdf (3 pages)
ARA_Item_3.1a_A&A Progress Report January 23 amended.pdf (12 pages)

3.2. Internal Audit Review Reports:

Attached *Head of Internal Audit*

3.2.1. Looked After Children

ARA_Item_3.2a_PTHB-2223-05-Looked After Children-Final Internal Audit Report.pdf (12 pages)

3.2.2. Cancer Services - Access to Symptomatic Fit

ARA_Item_3.2b_PTHB2223-11 Cancer Services Final Internal Audit Report.pdf (12 pages)

3.2.3. Women and Children's Services

ARA_Item_3.2c_PTHB2223.18 Women and Childrens Services - Final Internal Audit Report.pdf (14 pages)

3.2.4. Machynlleth Hospital Reconfiguration Project

ARA_Item_3.2d_PTHB 2022.23 Machynlleth Audit Final Report.pdf (28 pages)

3.2.5. North Powys Wellbeing Programme

ARA_Item_3.2e_PTHB 2223-16 North Powys Wellbeing Programme Final Internal Audit Report.pdf (23 pages)

3.2.6. Charitable Funds

ARA_Item_3.2f_PTHB 2223-08 Charitable Funds Final Internal Audit Report.pdf (17 pages)

3.2.7. Workforce Futures Strategic Framework

ARA_Item_3.2g_PTHHB-2223-04 Workforce Futures Strategic Framework Final Internal Audit Report.pdf (15 pages)

3.2.8. Welsh Language Standards

ARA_Item_3.2h_PTHB2223.13 WLS Final Audit Report.pdf (25 pages)

3.3. External Audit Progress Report 2022-2023

Attached *External Audit*

ARA_Item_3.3 Update January 2023 Audit Wales.pdf (10 pages)

3.4. External Audit Reports: Renewal Portfolio Report

To Follow *External Audit*

ARA_Item_3.4_ Audit Wales 3320A2022 Powys Renewal Portfolio Report - Final.pdf (18 pages)
ARA_Item_3.4a_Organisational Response to AW Renewal Portfolio Report.pdf (6 pages)

3.5. External Audit Structured Assessment Update

Oral *External Audit*

3.6. Counter Fraud Update

Attached *Head of Local Counter Fraud Services*

ARA_Item_3.6_Counter Fraud Update Report cover paper.pdf (3 pages)
ARA_Item_3.6a_Counter Fraud Update Report.pdf (4 pages)
ARA_Item_3.6b App 1 - Counter Fraud Statistical Benchmark Analysis amended.pdf (5 pages)
ARA_Item_3.6c_ App 2 - Proactive Exercise Standards of Behaviour Policy Compliance.pdf (11 pages)
ARA_Item_3.6d_App 3 Counter Fraud Investigations Update Report.pdf (3 pages)

3.7. Losses and Special Payments Update Report

Attached *Director of Finance and IT*

ARA_Item_3.7_Losses and Special Payments Interim Report 2022-23 QS updated.pdf (9 pages)
ARA_Item_3.7a_Appendix Bi - WRP Annual Review 2021-22 ENGLISH.pdf (55 pages)
ARA_Item_3.7b_Appendix Bii - Supplement (PTHB) WRP-LARS Annual Review.pdf (8 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

4.1. Review of Committee Programme of Business

Attached *Board Secretary/Director of Finance and IT*

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

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

Ora *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting: Tuesday 21 March 2023 at 10:00, Microsoft Teams.

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 31 JANUARY 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 15 November 2022	Attached	Chair
	1.4	Matters Arising from the Previous Meeting	Oral	Chair
	1.5	Audit, Risk & Assurance Committee Action Log	Attached	Chair
	2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
10:15	2.1	Application of Single Tender Waiver	To Follow	Director of Finance and IT
	3	**ITEMS FOR ASSURANCE**		
10:30	3.1	Internal Audit Progress Report 2022-2023	Attached	Head of Internal Audit
10:40	3.2	Internal Audit Review Reports: a) Looked After Children *(Substantial Assurance)* b) Cancer Services – Access to Symptomatic Fit *(Substantial Assurance)* c) Women and Children's Services *(Substantial Assurance)* d) Machynlleth Hospital Reconfiguration Project *(Reasonable Assurance)*	Attached	Head of Internal Audit

		e) North Powys Wellbeing Programme *(Reasonable Assurance)* f) Charitable Funds *(Reasonable Assurance)* g) Workforce Futures Strategic Framework *(Reasonable Assurance)* h) Welsh Language Standards *(Limited Assurance)*		
11:00	3.3	External Audit Progress Report 2022-23	Attached	External Audit
11:10	3.4	External Audit Reports: a) Renewal Portfolio Report	To Follow	External Audit
11:20	3.5	External Audit Structured Assessment update	Oral	External Audit
11:30	3.6	Counter Fraud Update	Attached	Head of Local Counter Fraud Services
11:40	3.7	Losses and Special Payments Update Report	Attached	Director of Finance and IT
	4	**ITEMS FOR DISCUSSION**		
11:50	4.1	Review of Committee Programme of Business	Attached	Board Secretary/Director of Finance and IT
	5	**OTHER MATTERS**		
11:55	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
12:00	5.3	Date of the Next Meeting: Tuesday 21 March 2023 at 10.00, Microsoft Teams		

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 15 NOVEMBER 2022 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:

Debra Wood-Lawson	Director of Workforce and OD
Pete Hopgood	Director of Finance and IT
Ian Virgil	Head of Internal Audit
Sarah Pritchard	Head of Financial services
Bethan Hopkins	External Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	Internal Audit
James Quance	Interim Board Secretary

Committee Support

Stella Parry	Interim Corporate Governance Manager

Apologies

None

ARA/22/077	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/22/078	**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/22/079	**MINUTES OF THE MEETINGS HELD 27 SEPTEMBER 2022** The minutes of the meetings held on 27 September 2022 were RECEIVED and AGREED as being a true and accurate record.
ARA/22/080	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were discussed.
ARA/22/081	**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): The Director of Finance and IT reported that updates in relation to these actions would be provided to the Committee on 31 January 2023. • 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/22/082	**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 September 2022 and 31 October 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
POW2223031	Quote	Getronics	Maintenance of Telephone System Switches	Continuation of Arrangements/Value for Money	15/09/2022	£24,600	1 year	Part - Retrospective	A1
POW2223032	TENDER	Adcuris Consulting	Demand Capacity and Financial Modelling In Support of service change from Strategic Outline Case to Outline Business Case	Continuation of work linked to previous undertaking and timescale (Links to STW POW2122018)	22/09/2022	£36,000	1 year	Prospective	A2
POW2223034	TENDER	British Pregnancy Advisory Service (BPAS)	Provision of Termination of pregnancy and Vasectomy for Powys Patients	Absence of viable NHS Supplier. Continuation of arrangement until national framework for these services is in place which is anticipated to be Autumn 2021.	26/10/2022	£153,090	12 Months	Part - Retrospective	A3

Independent Members sought assurance by asking the following questions:
POW2223031 had been considered 7 months into the financial year, why had it not been considered sooner?
The Director of Finance and IT confirmed that the STW was somewhat retrospective due to a delay in procurement process, it was highlighted that this matter would be addressed in response to action ARA/22/034.

In relation to POW2223031 how many times had the £700 day rate been utilised to date?
The Head of Financial Services noted that there had been no reports that the day rate had been utilised, though this would be checked and confirmed outside of the meeting.

Was Director of Finance and IT assured that procurement process in relation to POW2223032 had been proper and correct given the abscondment of the first contractor resulting in appointment of the second contractor, resulting in an increased cost of 30%?
The Director of Finance and IT reported that NWSSP Procurement Services had supported the process and it was confirmed that this query would be raised with procurement colleagues as part of the wider piece of work underway in relation to action ARA/22/047.

	The Committee RATIFIED the use of Single Tender Waiver in respect of 1 item during the period of 1 September 2022 and 31 October 2022.
ARA/22/083	**INTERNAL AUDIT PROGRESS REPORT 2022-23** The Head of Internal Audit presented the item which provided an overview of the progress against the 2022-23 Internal Audit Plan to date. It was noted that the plan for 2022/2023 was agreed by the Audit, Risk and Assurance Committee in April 2022 and is delivered as part of the arrangements established. The following matters where highlighted for the Committee's attention: • Since the last meeting of the Committee four audits had been finalised, with a further two at the draft report stage. Six audits were at work in progress with a further six at planning stage. • A Draft Limited Assurance Report at in relation to Welsh Language Standards had been considered by the health board's Executive Committee on 9 November 2022, it had been agreed that further time was required to develop an appropriate Management Response, therefore this item would be reported to the Audit, Risk and Assurance Committee on 31 January 2023. The Committee DISCUSSED and NOTED the update and AGREED the proposed changes to the 2022-23 Internal Audit Plan.
ARA/22/084	**INTERNAL AUDIT REPORTS** *a) Control of Contractors: Follow Up (Substantial Assurance)* The Committee received the report which sought to determine the status of agreed high and medium priority audit recommendations arising from the 2021/22 Control of Contractors audit. The 2021/22 report determined a limited assurance rating, with a number of significant matters identified, placing the health board at risk of potential Health and Safety Executive action in the event of adverse incidents occurring on site. Agreed actions from the prior review had largely been implemented, with 6 of the 7 recommendations now closed (including 3 high priority matters). Only one matter remained partially outstanding, in relation to site-specific signing in protocols. Recognising the controls already implemented by the Estates team, the recommendation priority had been lowered from high to medium; with the remaining actions, due to their nature, to be undertaken in conjunction with the wider health board. *b) Staff Rostering (Reasonable Assurance)* The Committee received the report which provided an overview of the controls and processes in place for the planning and management of staff rosters focusing on nursing rosters. The report provided a rating of Reasonable Assurance with matters arising requiring attention in relation to the Staff Rostering Policy and the HealthRoster system.

	Independent Members sought assurance by asking the following questions: *What were the financial implications of the usage of bank staff to fulfil rosters?* The Director of Finance and IT confirmed that effective rostering and the associated reduction in gaps was directly related to bank and agency usage, which was a key area if financial pressure for the health board. The Director of Workforce and OD confirmed that improvement work was underway in relation to ward establishments, which would be reported to a forthcoming meeting of the appropriate Board Committee. *c) Decarbonisation (Not Rated)* The Committee received the report, and it was noted that due to implementation plans having not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees across Wales the decision had been taken to affirm common themes within the report, to provide an overview of the overarching position across NHS Wales. An action plan of common All Wales themes was appended to the report. Independent Members sought assurance by asking the following questions: *It was suggested that the auditing of plans would be useful to assist health board Committees to scrutinise performance in this area, was there an estimation of when a full, non-advisory audit of plans would take place on an individual health board basis?* The Head of Internal Audit suggested that it was the intention to include decarbonisation as a regular annual audit within future Internal Audit Plans. *d) Security Services (Reasonable Assurance)* The Committee received the report which undertook an assessment of the structure and effectiveness of Security Services within the health board. The report provided a rating of Reasonable Assurance, with matters arising requiring attention in relation to the Security Policy, Security Plans and Governance arrangements. Independent Members sought assurance by asking the following questions: *Which health board Committee provided oversight in relation to health and safety matters?* The Board Secretary confirmed that matters in relation to health and safety would initially be considered by the Delivery and Performance Committee. *Had consideration been given to the inclusion of a briefing on security as part of the health board induction, as is in place for health and safety and fire?*

	The Director of Finance and IT and Director of Workforce and OD confirmed that consideration would be given to the inclusion of a security briefing within the health board's induction. The Committee received and NOTED the Internal Audit Reports.
ARA/22/085	**EXTERNAL AUDIT PROGRESS REPORT 2022-23** External Audit presented the item which provided an update on current and planned Audit Wales work. Information was also provided on the Auditor General's wider programme of national value-for-money examinations and the work of the Good Practice Exchange (GPX). The Committee NOTED the following audits currently underway: • Orthopaedic services – follow-up; • Renewal Programme; • Review of Unscheduled Care; • Structured Assessment; and; • Primary Care Services - follow-up review Independent Members sought assurance by asking the following questions: *Would the report on Unscheduled Care include the potential impact of poor performance and the consequences on the wider system?* It was confirmed that the scope of the report was extensive and would include elements such as patient flows into community settings and social care, access to services via GPs, 111 and Emergency Departments, and National and Welsh Government Policy and Guidance. The intention of the report was to provide insight into the key factors causing the wide ranging system issues being experienced by the NHS. *Would there be an opportunity for Independent Members to be involved in the Primary Care Services follow-up review?* It was confirmed that this would be checked with the Head of External Audit and fed back to members. The Committee DISCUSSED and NOTED the Report and welcomed the increased usage of interactive datasets.
ARA/22/086	**EXTERNAL AUDIT REPORTS:** The Committee received and NOTED the following Audit Wales reports for information: *a) National Fraud Initiative in Wales 2020-21* *b) Equality Impact Assessments: more than a tick box exercise?*
ARA/22/087	**ANNUAL GOVERANCE PROGRAMME REPORTING** The Board Secretary presented the item which provided an update on progress against the Annual Governance Programme, the update provided as of Q2 highlighted the following progress made since the last report: • development of induction for Independent Members; • filling of all board vacancies;

	• increased board development time focussed on key challenges at an early stage; and • review and refresh of the risk management framework and risk appetite statement. The Committee DISCUSSED and NOTED the update.
ARA/22/088	**AUDIT RECOMMENDATION TRACKING** The Board Secretary presented the item which provided 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 30 September 2022. The Head of Internal Audit noted that a follow up review in relation to Audit Recommendation Tracking was due to be undertaken in Q4. The Committee DISCUSSED and NOTED the Audit Recommendations Tracking Report.
ARA/22/089	**WELSH HEALTH CIRCULAR TRACKING** The Board Secretary presented the item which provided an overview of the position relating to the implementation of Welsh Health Circulars (WHCs). It was highlighted that it had been identified that not all WHCs were fully applicable to the services provided by the health board and had therefore been classified as partially complete pending further review by the Medical Director. The Committee DISCUSSED and NOTED the Welsh Health Circular Tracking Report.
ARA/22/090	**RISK MANAGEMENT FRAMEWORK** The Board Secretary presented the item and highlighted that the Risk Management Framework and Risk Appetite Statement was subject to annual review in order to ensure it fully reflected arrangements for risk management processes across the organisation and remained fit for purpose. Following review, no fundamental changes to the Risk Management Framework were proposed. The proposed revised Risk Appetite Statement sought to recognise the changing nature of the external environment that the health board operates in and the need for greater clarity and granularity to aid decision making and the treatment of risk. Independent Members sought assurance by asking the following questions: *What was the practical application of the Risk Appetite Statement within the organisation?* The Board Secretary highlighted that the Risk Appetite Statement sought to provide guidance on the Board's appetite for risk to be utilised when planning, allocating resources and making strategic decisions. The Head of Internal Audit agreed and recognised the strategic significance of the statement.

	The Committee DISCUSSED the Risk Management Framework and Risk Appetite Statement and NOTED that the revised documents were due to be presented to the Board on 30 November 2022.
ARA/22/091	**COMMUNITY HEALTH COUNCIL TRANSFER UPDATE** The Director of Workforce and OD presented the item which provided an update on the arrangements and progress on the transfer of the Community Health Councils Wales (CHC) function, staff and resources from Powys Teaching Health Board to a newly created Welsh Government Sponsored Body on 1st April 2023. It was reported that the process would be undertaken via a "TUPE style exercise," following the principals of the Transfer of Undertaking (Protection of Employment) Regulation 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 This is explicitly cited within Section 401 of the Health and Social Care (Quality and Engagement) (Wales) Act Explanatory Memorandum, June 2020. It was proposed that circa 90 staff employed in the CHCs (Community Health Councils) will transfer to the CVB on April 1st 2023. At the time of the meeting the CHC staff were employed by health board and work under the direction of the CHC Chief Officers, CHC Chief Executive and CHC Boards. The proposed change would transfer the employment of staff and resources to the CVB. The Committee DISCUSSED and NOTED Community Health Council Transfer Update.
ARA/22/092	**REVIEW OF COMMITTEE PROGRAMME OF BUSINESS** The Committee RECEIVED and NOTED the Committee programme of business. It was noted that a number of Internal Audit Reports were due to be presented to the Committee in January, therefore it was AGREED that the reporting on Audit Recommendations would next return to the Committee in March 2023 to enable a greater allocation of time to review the anticipated audit reports.
ARA/22/093	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no matters to be brought to the attention of the Board and other Committees.
ARA/22/094	**ANY OTHER URGENT BUSINESS** No other urgent business was declared. It was noted that the Chair, with advice from the Board Secretary, had determined that there were items for consideration by the Committee which included confidential or commercially sensitive information which was not in the public interest to discuss in an open meeting. An In-Committee meeting of the Audit, Risk

	and Assurance Committee was due to be held at 12pm for consideration of these items.
ARA/22/095	**AUDIT, RISK AND ASSURANCE IN-COMMITTEE** A meeting of the Committee was held in closed session in which consideration was given to digital infrastructure and cyber security, and the Audit Wales report on Learning from Cyber Attacks. The Committee DISCUSSED and NOTED the items and AGREED the following next steps: • A Board-level overview report would be developed for sharing with the wider Board at a future Board Briefing or Board In-Committee; • A timescale for reassessment would be developed and agreed; • An assessment would be undertaken to determine the essential/minimum requirements in relation to cyber security to inform the considered allocation of the resources for 2023-24; and • Consideration would given to the potential for partnership working with other public sector organisations in Wales.
ARA/22/096	**DATE OF NEXT MEETING** 31 January 2022, 10:00 am, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue

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Powys Teaching Health Board

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(31 January 2023)

Minute	Date	Action	Responsible	Progress	Status
ARA/22/034	13 June 2022	A 'Register of Contracts' linked to the Single Tender Waiver process would be developed.	Director of Finance & IT	The Head of Financial Services has liaised with Procurement Services and a response for this is included within Agenda Item 2.1 Single Tender Waiver	Completed
ARA/22/047	18 July 2022	Work would be undertaken alongside procurement to develop an approach to ensure maintenance costs were included in original procurement costs to enable an upfront position of the cost of the contract to be provided.	Director of Finance & IT	The Head of Financial Services has liaised with Procurement Services and a response for this is included within Agenda Item 2.1 Single Tender Waiver	Completed
ARA/22/048	18 July 2022	The paper provided to the Executive Committee and	Director of Finance & IT	A paper to include a trend analysis including Welsh Risk Pool	Completed

		Patient Experience, Quality and Safety Committees which provided a trend analysis of Losses and Special Payments would be shared with Members for information.		benchmarking is included as an attachment of Agenda item 3.7 the interim Losses and Special Payments report	
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 to be provided to the Delivery and Performance Committee scheduled for February 2023	Not yet due

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 31st January 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 November 2022 and 31 December 2022.

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 November 2022 and 31 December 2022.

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 November 2022 meeting which covered the period from 1 September 2022 and 31 October 2022.

A summary of the use of Single Tender Action from 1 November 2022 and 31 December 2022 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	Appe 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

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.

Process of STW and Contract arrangements

Further to queries raised at previous committee meetings the Head of Financial Services has met with procurement colleagues to ascertain some clarification to these requests. These are responded to as follows:

A query was raised as to whether a contract register is produced for STW related items. It is confirmed that procurement services hold a Single Tender Waiver Register which is a live register regularly updated for the status of each request once distributed to the service and updated for contract amounts and timeframes. Upon completion of the approved STW, procurement Business Managers will identify any contracts that may include a repetitive element and include these in the procurement department workplan. This will then lead to joint work with a service to produce a specification for future procurement/tender where possible / suitable suppliers to tender for. Where an alternative procurement route has not been possible to undertake it should be explained within any repeating STW's to explain why.

A further query has also been raised whether procurement encourage service areas to develop an approach to include related and unavoidable future year costs (e.g., maintenance costs) in the STW process (to enable an upfront position where the cost of the whole life contract to be provided). It has been confirmed by procurement colleagues that a whole life contract approach is taken when completing the procurement process. It should be noted that upon request for a STW form to be distributed for completion, several compulsory questions are required to be responded to so that the procurement service can understand the business need for that purchase. From these responses the procurement service assesses if there is an alternative route for procurement such as framework or if within quotation thresholds (5k to 25k), undertaking a streamlined multi quote approach. These compulsory questions have resulted in a reduction in the numbers of STW's being requested / approved within PTHB. These compulsory questions also ask for details of future costs such as maintenance etc in reference to the whole life costs approach.

Action continues to maximise education and awareness and support in relation to procurement best practice and this is helping to maintain STW's at the low level as being actioned in PTHB.

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: 3.1

Audit, Risk and Assurance Committee	**Date of Meeting: 31 January 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:	N/A

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.

Approval	Discussion	Information
		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 eight audit reports have been finalised since the November 22 meeting of the Committee:

- Looked After Children Health Assessments (Substantial Assurance)
- Cancer Services - Access to Symptomatic FIT (Substantial Assurance)
- Women and Children's Services (Substantial Assurance)
- Machynlleth Hospital Reconfiguration Project (Reasonable Assurance)
- North Powys Wellbeing Programme (Reasonable Assurance)
- Charitable Funds (Reasonable Assurance)
- Workforce Futures Strategic Framework (Reasonable Assurance)
- Welsh Language Standards (Limited Assurance)

The progress report also includes details of a proposed addition to the 2022/23 plan and an update on development of the 2023/24 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
January 2023

NWSSP Audit and Assurance Services

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

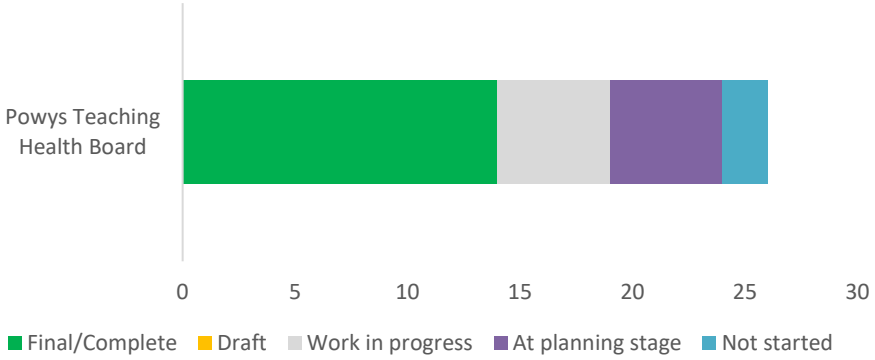
Eight assignments from the 2022/23 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Looked After Children Health Assessments	Substantial	
Cancer Services - Access to Symptomatic FIT		
Women and Children's Services		
Machynlleth Hospital Reconfiguration Project	Reasonable	
North Powys Wellbeing Programme		
Charitable Funds		
Workforce Futures Strategic Framework		
Welsh Language Standards	Limited	

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 26 reviews included within the 2022/23 Internal Audit Plan (including the additional audit detailed under section 4 below), and overall progress at this early stage of the year is summarised below.



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

In addition, there are five audits that are currently work in progress with a further five 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

- **Addition of Occupational Health: Follow-up**

  A detailed follow-up audit has been added to the plan, for the previously limited assurance report on Occupational Health.

5. Development of the 2023/24 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors during January and February to discuss potential areas for inclusion within the 2023/24 Internal Audit Plan.

An initial draft of the plan will then be discussed with the Board Secretary, Chief Executive, and Independent Members. It will also be submitted to a meeting of the Executive Team for review.

The updated plan will then be presented to the Audit, Risk and Assurance Committee for formal approval at the March 2023 meeting.

6. Engagement

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

Board / Sub Committees

- Board – 30 November

Health Board Meetings

- Hayley Thomas, Executive Director of PC&MH – 10 January
- Kate Wright, Medical Secretary – 11 January
- Claire Roche, Executive Director of Nursing & Midwifery – 11 January
- Pete Hopgood, Executive Director of Finance, Information & IT – 12 January
- Claire Madsen – Executive Director of Therapies and Health Science – 17 January
- Jamie Marchant – Director of Environment – 17 January
- Debra Wood-Lawson – Executive Director of Workforce & OD – 17 January
- Stephen Powell – Executive Director of Planning & Performance – 20 January
- Audit Wales – 26 January

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
Temporary Staffing Department	Review of systems and controls covering requesting, authorising & paying of bank & agency staff	3	Workforce & OD	~~1~~	3	Work in Progress		March
Cyber Security	The organisation is working to improve its cyber security position, and appropriate reporting is in place that shows the current status.	10	Finance, Information & IT	~~3~~		Work in Progress		March
Incident Management	Review the arrangements in place for the identification, recording, investigation and management of incidents.	6	Nursing & Midwifery	3		Work in Progress		March
Professional Governance Structure	Implementation of structure to provide assurance on professional oversight.	14	Therapies & Health Science	~~4~~	3	Work in Progress		March
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		Work in Progress		March
Planned Care / Recovery of backlog Services	Provide assurance across key areas - Community Services / planned care / recovery of backlog services	17	Planning & Performance	3		Planning		March
Covid 19 – Outbreak Control Plan Contact Tracing	Use of WG contact tracing funding to allow health Staff to respond to Covid outbreaks.	19	Public Health	~~2~~	3	Planning		March
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		Planning - Brief agreed for February start		March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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				March
Board Assurance Framework / Risk Management	Focus on development of effective assurance processes alongside risk identification / escalation.	1	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
Occupational Health Follow-up	Follow-up of 21/22 Limited Assurance report to establish progress with implementation of agreed actions.	26	Workforce & OD	4				May

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

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% 14 from 14	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	79% 11 from 14	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 14 from 14	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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Looked After Children Health Assessments

Final Internal Audit Report

December 2022

Powys Teaching Health Board

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

Review reference:	PTHB-2223-05
Report status:	Final
Fieldwork commencement:	September 2022
Fieldwork completion:	December 2022
Debrief meeting:	14th November 2022
Draft report issued:	6th December 2022
Management response received:	6th December 2022
Final report issued:	6th December 2022
Auditors:	Andrea Calise – Principal Auditor Jayne Gibbon – Audit Manager
Executive sign-off:	Claire Roche – Director of Nursing & Midwifery
Distribution:	Jayne Wheeler-Sexton – Assistant Director of Nursing Safeguarding & Public Protection Rachel Lewis – Safeguarding Business Support Manager
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 provide assurance that effective processes are in place to ensure that LAC Health Assessments are appropriately completed for all relevant looked after children, in accordance with the requirements of "The Framework".

Overview

We have issued Substantial Assurance on this area. The LAC Team have developed comprehensive procedures and have robust processes in place which are working effectively and adhere to the best practice standards set out within "The Framework". Our testing noted that the LAC Team take a pro-active approach to the Health Assessment process, and we could evidence that the LAC Team work above and beyond their roles and responsibility to ensure that looked after children receive a Health Assessment as soon as they become looked after.

We have identified one matter that requires management attention, around the need to ensure that appropriate data validation checks are undertaken on the LAC monitoring spreadsheet.

Report Opinion

Substantial

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 guidance	Substantial
2	LAC Health Assessments	Substantial
3	Health professional allocation	Substantial
4	Care planning	Substantial
5	Data and patient record monitoring	Reasonable
6	Governance arrangements	Substantial
7	Partnership working	Reasonable

[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	Monitoring data entry check	5	Control Design	Medium

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1. Introduction

1.1 Our review of Looked After Children Health Assessments was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 Looked After Children (LAC) share many of the same health risks and problems as their peers, but often to a greater degree and in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect before they enter the care system. LAC are children up to the age of 18 for whom the Local Authority is providing accommodation or care for a period of more than 24 hours (Children Act 1989).

1.3 There is a statutory requirement for the Health Board to provide health assessments for LAC and commission secondary services for Powys LAC who are placed out of county. The statutory LAC health assessment provides a vital interface with a specialist health professional and the opportunity to identify and address health needs and have a positive impact on health outcomes.

1.4 A health assessment for a child or young person in care is a holistic assessment of their physical, emotional and behavioural needs. The assessment also includes aspects of health education and health promotion. It is not an isolated event, but part of a process of continuous care including monitoring and promoting the child's health. A quality LAC health assessment is essential for improving health outcomes in the short and long term.

1.5 The NHS Wales Health Assessment Framework for Looked After Children (the 'Framework') provides standards of good practice for Health Boards working with children who are currently Looked After by the local authority, including those who are being twin tracked for adoption.

1.6 The potential risks considered in this review were as follows:

- Health assessments are not effectively completed in line with the requirements of the Framework;
- LAC do not receive appropriate care leading to potential harm or deterioration of health; and
- Potential issues relating to LAC health assessments may not be effectively identified, reported or addressed.

2. Detailed Audit Findings

Objective 1: There is an up-to-date Health Board policy and local guidance in place to support the Framework and completion of LAC health Assessments.

2.1 The Health Board's Safeguarding Policy was reviewed and approved by the Policy Group and Executive Committee in September 2021. The policy sets out the Health Board's overarching arrangements for complying with the legislative requirements of the Social Services and Well-being (Wales) Act 2014.

2.2 The Health Board has also developed the "Looked After Children Guidance for Professionals" procedures which were reviewed and approved by the PTHB Safeguarding Strategic Group in April 2022 which reflects the principles and requirements of the NHS Wales Looked After Children - Health Assessment Framework ("The Framework").

2.3 We were able to confirm that both the Safeguarding Policy and the Looked After Children (LAC) Procedures had been made available to staff via the Health Board's intranet.

2.4 The Health Board has adopted the Framework's Best Practice standards within its Health Assessment template.

Conclusion:

2.5 We are satisfied with the comprehensive policies and procedures developed by the Health Board to guide and support the Health Assessment process. The policies and procedures were developed adopting the best principles set out within The Framework. Therefore, we have provided Substantial Assurance for this objective.

Objective 2: Initial health assessments and review assessments are completed for all LAC notified by the local authority, in accordance with the requirements and timescales stated within the Framework.

2.6 The LAC Team have robust processes in place for ensuring that all LAC, as notified by the Local Authority (Powys), undergo an initial Health Assessment (IHA) and Review Health Assessment (RHA) in line with the requirements and timescales of the Framework.

2.7 Copies of Health Assessments are saved by the LAC Team to the Welsh Community Care Information System (WCCIS) and are shared with the relevant health professional that is directly involved in the provision of health and wellbeing care for the child/young person being looked after (this can include GP, and School Nurse/ Health Visitor/Community Paediatric Nurse etc).

2.8 We selected a random sample of Health Assessments (Both IHA's and RHA's), completed by the Powys LAC Team since April 2022. No significant issues were identified, and documentation/evidence was available to confirm compliance with the requirements and timescales of the Framework.

Conclusion:

2.9 Out testing confirmed that the Health Board has robust processes in place to ensure that the Health Assessment process for children/young people is performed by the LAC Team in accordance with the Framework. We have therefore provided Substantial Assurance for this objective.

Objective 3: An appropriate lead health professional is identified for all LAC.

2.10 Following the notification of a looked after child/young person from the local authority, the Safeguarding Business Support Manager (SBSM) and the LAC Administrator will review and assess the information and assign one of the two LAC Specialised Nurses.

2.11 The SBSM confirmed that the child/young person's location is a primary factor in deciding the allocation as one of the nurses covers North and Mid-Powys and the other nurse covers South and Mid-Powys.

2.12 If a Powys child/young person is placed outside of county, the LAC Team still has responsibility and allocation would be dependent on current nurse workloads/capacity. Testing revealed that for all cases selected, each child/young person had been allocated with a lead health professional.

Conclusion:

2.13 The LAC Team effectively assign a lead health professional to all looked after Powys children/young people as notified by the Local Authority. We have therefore provided Substantial Assurance for this objective.

Objective 4: A care plan is developed with effective ongoing monitoring and delivery.

2.14 A review of the Health Board's procedures, and findings from our Health Assessment sample testing confirmed, that care plans and health recommendations are considered as part of the process. An action plan is developed within the Health Assessment form and is completed with the route/reason for the health recommendation, the assigned responsibility and due date for meeting the recommendation.

2.15 Health recommendations/care plans are reviewed as part of the quarterly LAC reviews between the LAC Nurse/Health Visitor and the parent/guardian to discuss the looked after child's progress.

2.16 We reviewed the health recommendations/care plans set for the sample selected for Objective 2 and can confirm that any urgent referral/action by the LAC Team had been actioned appropriately and in a timely manner. Evidence of referrals/actions was found to be stored within the "Case notes" section of the WCCIS system.

Conclusion:

2.17 The LAC Nurses develop health recommendations/care plans and effectively review progress of implementation as part of the LAC review process. Our sample testing did not identify any issues as the progress of referrals/actions was evidenced within

the WCCIS system. We have therefore provided Substantial Assurance rating for this objective.

Objective 5: Robust processes and systems are in place for the recording and on-going monitoring / review of LAC health assessments.

2.18 The LAC Team monitors overdue and upcoming Health Assessments via the LAC Spreadsheet. The document, which is securely held and saved to one drive, is only available to the LAC Team and captures key information that informs the Health Assessment process.

2.19 The LAC spreadsheet is maintained by the SBSM and by the LAC Administrator and is shared with the two LAC Nurses so that they are aware of upcoming actions and Health Assessments due. We performed basic data validation checks of the LAC spreadsheet and identified a number of data entry issues which were due to human error. (Matter Arising 1)

2.20 We noted that the Health Board has embedded a Quality Assurance process for reviewing and assessing the quality of Health Assessments performed by LAC Nurses/Health Visitors. We were able to confirm that spot checks are being completed in a timely manner by the SBSM and at the time of our review, there had not been any significant issues identified from the process.

Conclusion:

2.21 The LAC Team has established robust arrangements for monitoring the Health Assessment process and compliance with the Framework. We did identify a number of minor anomalies in the document in place. We have therefore provided Reasonable Assurance for this objective.

Objective 6: Appropriate governance arrangements are in place which provide effective oversight of the LAC health assessment process, with regular reporting to relevant Health Board groups and / or committees.

2.22 The Assistant Director of Nursing Safeguarding and Public Protection oversees the LAC Team which comprises of the Safeguarding Support Manager, the LAC Team Administrator and two Specialised Clinical Nurses (LAC Nurses). The roles and responsibilities of the Team were found to be clearly defined within the procedures in place.

2.23 The LAC Team formally meets to review and discuss the Team's progress, on-going issues and objectives set within the Team's action plan. We were provided with minutes to confirm that meeting take place on a quarterly basis.

2.24 The LAC Team reports directly to the Health Board's Safeguarding Strategic Group and contribute to the information contained within the Strategic Safeguarding Report that identifies safeguarding good practice, themes, issues, risks and compliance with statutory legislation. Performance data regarding the Health Assessment process and Looked After Children is also included within the report.

2.25 LAC is one of the safeguarding themes included within the Annual Safeguarding Report presented to the Health Board's Patient Experience, Quality and Safety Committee. A review of the governance documentation confirmed that the latest

Safeguarding Annual Report 2021-22 was presented to the Patient Experience, Quality and Safety Committee in November 2022[1].

Conclusion:

2.26 The Health Board has appropriate governance arrangements in place that currently provide effective oversight and scrutiny over the Health Assessment process. The LAC Team report performance on a quarterly basis through the Strategic Safeguarding Report, annually to the Patient, Quality and Experience Committee and regularly attends regional/national safeguarding network groups. We have provided Substantial assurance for this objective.

Objective 7: There is effective partnership working between the Health Board and Social Services and other relevant external organisations and groups.

2.27 The Health Assessment process for Looked After Children requires co-ordination and effective partnership working between the LAC Team, the Local Authority, (Social Workers) placements and parents/guardians of LAC and Health Professionals (Health Visitors/GP's/School Nurses etc.).

2.28 Discussions with the LAC Team and a review of the LAC Spreadsheet and the monitoring data reported to the Powys Corporate Parenting Group identified that a number of factors can impact on the LAC Team's ability to complete Health Assessment's in line with the timescales set out within 'The Framework'. Often these factors are external to the Health Board's arrangements and relate to the roles and responsibilities of the local authority with respect to the Health Assessment process.

2.29 The SBSM and the LAC Administrator regularly engage with representatives from the looked after children department of local authorities and will highlight and discuss local authorities' issues that are impacting on undertaking health assessments.

2.30 The LAC Team also provides input into wider safeguarding networks with regular representation on the LAC Cymru Nurses Group, the All-Wales LAC Steering Group (Hosted by Public Health Wales and attended by other NHS Wales Health Boards) and the Powys Corporate Parenting Group hosted by Powys County Council.

Conclusion:

2.31 There are appropriate partnership working arrangements in place between the Health Board and local authorities and external groups. The actions of partner organisations do have an impact on the timely completion of health assessments for out of county LAC and we have therefore provided reasonable assurance for this objective. We acknowledge that the LAC team are working to address these issues and have implemented several processes to try and mitigate them, we have not therefore included any recommendation relating to this issue.

[1] https://pthb.nhs.wales/about-us/the-board/committees-partnerships-and-advisory-groups/powys-teaching-health-board-committees/1/meetings-of-the-patient-experience-quality-and-safety-committee/11/1/ (Item 3.1, Page 208)

Appendix A: Management Action Plan

Matter Arising 1: Monitoring data entry check (Control Design)	**Impact**
The LAC Team have reasonable arrangements in place to monitor the Health Assessments process. A Spreadsheet is maintained by the Safeguarding Business Support Manager and by the LAC Administrator which contains key information regarding the child/young person being looked after. This information is collated within the spreadsheet and is reviewed on a daily basis by the LAC Team to identify due and overdue Health Assessments. We reviewed the data held within the spreadsheet and our data validation checks identified a number of data entry anomalies, all of which were due to human error. Whilst the data errors were minor and did not impact on the Team's ability to monitor overdue Health Assessment, the process is still exposed to human error risk. The LAC Team are currently in the process of exploring alternative database/systems to automate the process and limit the need for manual data entry. Until such systems/database are found, we recommend that data checks be performed to ensure data is being entered in the LAC Spreadsheet correctly.	Potential risk of: • Potential issues relating to LAC health assessments may not be effectively identified, reported or addressed. • Health assessments are not effectively completed in line with the requirements of the Framework;

Recommendations		**Priority**
1.1	Management should ensure that Data entry checks are undertaken to ensure that information held within the LAC Spreadsheet is correct and up to date.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Weekly spot checks by Business support manager of the LAC spread sheet in place. Immediate action in progress and already commenced. The LAC Team had identified the LAC Spreadsheet needed to be updated due to the amount of information it was holding and the time involved in updating the data. The process of redesigning a new system that will improve data collection,	31 January 2023	Jayne Wheeler Sexton Assistant Director of Nursing, Safeguarding & Public Protection

	limit human error and enable a more efficient use of time has already commenced and will be ready for testing January 2023.		

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Cancer Services – Access to Symptomatic FIT

Final Internal Audit Report

December 2022

Powys Teaching Health Board

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Powys Teaching Health Board

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Auditors:	Sharon Edwards, Principal Internal Auditor Ian Virgill, Head of Internal Audit
Executive sign-off:	Kate Wright, Medical Director
Distribution:	Clare Lines, Assistant Director Transformation and Value Ruth Corbally, Cancer Clinical Lead Michael Griffiths, Transformation Programme Manager
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 and to provide assurance that the planned actions to allow improved access to symptomatic FIT are being effectively delivered.

Overview

We have issued substantial assurance on this area.

There are effective governance arrangements in place for the Cancer Renewal Programme, which includes improving access to FIT as one of its key pathways.

Access to FIT is now in place for all Powys residents and supporting guidance and training has been made available to all GP practices.

We only identified one key matter requiring management attention, relating to the need to ensure that a breakdown of FIT figures is received from the Wye Valley Trust.

A further low priority recommendation which is best practice in nature is captured within the detail of the report.

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	Effective Governance arrangements	Substantial
2	Clear pathways for accessing symptomatic FIT services.	Reasonable
3	Comprehensive guidance on pathways and provision of training	Substantial
4	Monitoring and reporting	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	Breakdown of FIT figures for mid Powys	2	Design	Medium

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1. Introduction

1.1 Our review of Cancer Services – Access to Symptomatic FIT was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 A strategic priority within the Health Board's Renewals Programme and Integrated Medium-Term Plan for 2022/3 – 2024/5 is to implement improvements in early diagnosis, treatment, and outcomes for people with or suspected of having cancer.

1.3 One of the key actions within the overall strategic priority is to improve access to symptomatic Faecal Immunochemical Testing (FIT) to enable early diagnosis.

1.4 FIT is a stool test designed to identify possible signs of bowel disease. It detects minute amounts of blood in faeces (faecal occult blood). Many bowel abnormalities which may develop into cancer over time, are more likely to bleed than normal tissue. So, if there is blood in the stool this can indicate the presence of abnormalities in the bowel. Patients with a positive FIT result are referred for further investigation by colonoscopy. If cancer is found early, treatments are more effective.

1.5 FIT is used for asymptomatic population-based bowel (cancer) screening and also for the assessment of patients presenting with lower abdominal symptoms, particularly in primary care.

1.6 The Lead Executive for this review is the Medical Director.

1.7 The potential risks considered in the review were as follows:

- Planned improvement actions around FIT are not effectively delivered.
- Potential patient harm due to delay in diagnosis; and
- Inequitable access to FIT for Powys residents.

2. Detailed Audit Findings

Objective 1: Effective Governance arrangements are in place for the ongoing embedding of FIT into practice as part of the Cancer Renewal Programme, with risks to delivery highlighted and appropriately managed / escalated.

2.1 The Renewal Strategic Portfolio Board (RSPB), along with the Cancer Programme Board and Cancer Programme Team oversee the governance arrangements and operation of the Cancer Renewal Programme. The structure is identified within the Programme Initiation Document which maps the various meetings and reporting lines between them.

2.2 The Cancer Renewal Programme Initiation Document was produced and approved in September 2021 by the RSPB. The RSPB is a Chief Executive-led Board which forms part of the Health Board's Executive Committee. The Programme Initiation Document includes information on the development of FIT testing as phase one of the programme. Further subsequent amendments to the Programme Initiation Document have also been presented to the RSPB.

2.3 The Cancer Renewal Programme Initiation Document was also presented in October 2021 to the Cancer Renewal Programme Board for information.

2.4 Presentations are given to the RSPB by the Assistant Director Transformation and Value. These provide an overview of where the organisation is with the programme, along with an update on "What we said we'd achieve - Cancer". The presentations include updates on:

- Protected Learning Time which includes information on the FIT process
- Raising awareness to access for symptomatic FIT services across all GP practices in Powys.

2.5 The Programme Risks also form part of the presentation and at present the Cancer Programme is scored over 15 which means there is a risk of death or significant harm for patients. Mitigating actions have been identified within the Cancer Programme but the risk remains high.

Conclusion:

2.6 We note that there is a structure in place and effective governance arrangements to embed the FIT process with issues and risks being highlighted as part of the Cancer Renewal Programme. We have provided Substantial Assurance for this objective.

Objective 2: Clear pathways have been developed to enable all primary care providers to access symptomatic FIT services for relevant individuals

2.7 As part of the Cancer Renewal Programme, various pathways have been identified within the Programme Workplan which includes the following FIT work activities:

- Identify access to FIT testing for all GP practices across Powys;
- Identify barriers to access;
- Where needed, negotiate access to FIT testing service with secondary care providers;
- Where needed confirm new arrangements with GPs; and
- Roll out FIT testing to all GPs across Powys.

The Transformation Programme Manager is the lead for these work activities.

2.8 The Programme Workplan applies a RAG status to each work activity and there is a progress section which details all issues that have been encountered during the roll out of the programme.

2.9 The Programme Workplan is a live document and was presented at the Cancer Programme Board in July 22 providing information on the status for the FIT pathway. There were two activities that were colour coded as blue which showed they had been completed. These were:

- Access to FIT testing is complete as a mapping exercise has been undertaken.

- Roll out of FIT testing carried out with virtual protected learning time sessions provided which provided sessions on FIT development for clinicians and sessions on supporting people affected by cancer, for non-clinical staff.

It also featured the following two work activities which were green meaning they were on track or within one week of the expected implementation date:

- Barriers to access FIT testing has been identified across South, Mid and North Wales with narrative to support the progress being made.
- Negotiations have taken place with SaTH regarding access to FIT testing service within secondary care

One work activity has been identified as Amber which means there is a risk of delay:

- Confirm new arrangements with GPs. This will take place once the new arrangements with SaTH have been finalised.

There is however narrative to support the amber status (risk of delay) and to show the work that is being undertaken.

2.10 The Symptomatic FIT service pathways have now been put in place and made available to all patients across the GP practices within North, South, and Mid Powys.

2.11 Data is received by the Transformation and Value team for GP practices across Powys which detail how many FIT tests were negative, positive, rejected and N/A. The figures correlate with the number of FIT tests that have been issued and show that the FIT pathway is being utilised.

2.12 Figures have been received for Public Health Wales which covers the North Powys and Ystradgynlais practices, along with Aneurin Bevan University Health Board which covers the GP practices within South Powys. However, at present there is an issue with the data being received from Wye Valley Trust which covers Mid Powys & Haygarth, as a breakdown of the figures has not been received. **(Matter Arising 1)**

Conclusion:

2.13 Clear pathways have been identified and implemented for symptomatic FIT service across the GP practices within Powys and safety netting advice has been given. Data needs to be consistently provided to ensure that all information is captured, and pathways are being followed. We have provided Reasonable Assurance for this objective.

Objective 3: Comprehensive guidance is in place and there is effective on-going communication of pathways and provision of training to relevant parties

2.14 Since the Clinical Lead has come into post, there has been more communication from the Health Board to the GP Practices and vice versa which has led to more engagement into the Cancer Programme. This has had a positive impact on the attendance at the Protected Learning Time session with a higher-than-expected number of people in attendance.

2.15 Protected learning time sessions which included sessions on FIT testing were held for South / Mid Powys and a separate one held for North Powys. In attendance were 142 clinical staff and 169 non-clinical staff.

2.16 Links to the "FIT Testing and the SaTH Colorectal Pathway" and "FIT in the symptomatic lower GI Pathway" presentations have been made available to all staff and GPs. Updates relating to the Cancer Renewal Programme which include information on symptomatic FIT testing process have also been highlighted to staff and GPs via the Health Board Cancer and End of Life Newsletters which are sent out on a regular basis. Within the newsletters there are links which allow staff to gain access to more information should they require it.

2.17 Although one medical practice did not attend the protected learning session, it is clear from the data that is being received by the Transformation and Value team within the Health Board that the guidance has been reviewed as the FIT pathway is being followed.

2.18 The Wales Cancer Network have developed a new Symptomatic FIT Pathway which will be attached to the National Optimal Pathway for Colorectal Cancer which is currently under review. This pathway has been developed in response to the new joint national guideline by the Association of Coloproctology of Great Britain and Ireland and British Society of Gastroenterology which was published in England in July 2022 and will ensure that there is a more consistent approach across all Powys, Wales, and England. The updated guidance on FIT Testing has been sent out via the October 22 Newsletter and it highlights the suggestions that are being made which will ensure a consistent approach to FIT pathways.

Conclusion:

2.19 Designated training sessions have been put on for non-clinical and clinical staff and information on the current FIT pathways has been made available to all GPs. Guidance has been recently updated to reflect the new joint national guidelines and these are available on the Health Board intranet. We have provided Substantial Assurance for this objective.

Objective 4: Arrangements are in place for the monitoring and reporting of the provision of FIT services.

2.20 The Cancer Renewal Programme Team meetings are held on a regular basis and feed into the Cancer Renewal Programme Board. The agendas provided show that discussions are held around all work activities including FIT services.

2.21 The Programme plan shows that the one FIT work activity which is at risk of delay has been discussed at the various levels of meetings and the narrative details the reasons for the delays and shows that work is being undertaken to meet the target deadline as soon as possible

2.22 The Programme team meetings discuss risks which relate to the Cancer programme and whether the risk levels can be reduced. The Risk around FIT

testing has been reduced as four of the five activities are either complete or on course for completion.

2.23 We saw evidence through the Cancer Renewal Programme Board that updates have been provided from the Programme team and that where there are any issues these are escalated further to the RSPB.

2.24 The Programme Initiation Document provides details of the membership of the Cancer Renewal Programme Board. We carried out testing on a sample of meeting minutes to establish if the meetings were quorate and had appropriate attendance. We identified that although the three meetings were quorate, there is a need to review the current stated membership to ensure that on-going attendance is appropriate. **(Matter Arising 2)**

2.25 The Transformation and Value team within Powys Teaching Health Board receive information relating to FIT tests to provide assurance that FIT testing is accessible to all the practices in Powys. We were informed that the data has been reviewed by the Cancer Renewal Programme Clinical Lead and reported to the Cancer Renewal Programme Board, RSPB, Delivery and Performance Committee and the National Endoscopy Programme.

Conclusion:

2.26 We note that there are effective arrangements in place for monitoring and reporting on the accessibility of FIT services. We have provided Substantial Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Breakdown of FIT figures for Mid Powys (Design)	Impact
To ensure that the pathway is being followed, symptomatic FIT data is received from Public Health Wales NHS Trust (PHW) which covers North Powys and Ystradgynlais GP practices, Aneurin Bevan University Health Board which covers the practices within South Powys and Wye Valley Trust which covers Mid Powys & Haygarth. The data from PHW and Aneurin Bevan is broken down into negative, positive, rejected and N/A results, which correlate with the number of tests that have been issued. However, at present there is an issue with the information being received from Wye Valley Trust, as although the overall testing figures have been provided there is no breakdown of the results.	Potential risk of: • Not being aware of inequitable access to FIT for Powys residents.

Recommendations		Priority
1.1	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Secure from Wye Valley NHS Trust on a monthly basis the required breakdown of data in relation to the tests issued.	January 2023	Kate Wright, Responsible Executive. (Supported by Mike Griffiths, Transformation Programme Manager)

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Matter Arising 2: Attendance at the Cancer Programme Board (Operation)	Impact
The Cancer Renewal Programme Initiation Document provides details of the membership of the Cancer Renewal Programme Board. Testing was carried out on the minutes that were provided for the meetings held in November 21, January 22 and April 22, to establish if they were quorate and included appropriate attendance. The testing established that although the three meetings were quorate, not all members were present or sent apologies to the three meetings.	Potential risk of: • PID not being up to date.

Recommendations		Priority
2.1	Management should review the membership of the Programme Board within the Programme Initiation Document to establish if it remains appropriate.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	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.	January 2023	Kate Wright, Responsible Executive. (Supported by Mike Griffiths, Transformation Programme Manager)

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Women and Children's Services
Final Internal Audit Report

January 2023

Powys Teaching Health Board

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Auditors:	Ian Virgill, Stuart Bodman
Executive sign-off:	Hayley Thomas, Director of Primary, Community & Mental Health
Distribution:	Louise Turner, Assistant Director of Women and Children's Services Lloyd Reader, Workforce & OD Business Partner Mary Cottrill, Head of Children's Public Health Nursing & Paediatric Services
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 evaluate and determine 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.

Overview

We have issued substantial assurance on this area.

Effective governance structures are in place within the Women and Children's Service, supported by robust risk management and financial management arrangements.

The workforce and risk management controls within the School Nursing and Health Visiting Departments are also well established and operating effectively.

We have only raised two low priority recommendations relating to:

- Consistent completion of Return-to-Work Interview documentation.
- Absence of dedicated/protected time and resources for Health Visitors and School Nurses to undertake online Mandatory Training.

Further information on the matters arising is detailed within Section 2 and Appendix A of the report.

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	Governance	Substantial
2	Workforce Management	Substantial
3	Risk Management	Substantial
4	Financial Management	Substantial

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

1. Introduction

1.1 Our review of Women and Children's Services was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The Women and Children's Service Group is part of the Primary, Community and Mental Health Service and is made up of the following departments:

- Midwifery Services;
- Sexual Health;
- Children's Community Nursing;
- School Nursing;
- Health Visiting;
- Paediatric Physiotherapy & Occupational Therapy;
- Speech and Language; and
- Community Paediatrics.

1.3 Our review focussed on the overarching governance and financial management arrangements of the Women and Children's Service Group, and the operational workforce and risk management processes in place within the School Nursing and Health Visiting departments.

1.4 We previously undertook a high-level review of risk management arrangements within the Women and Children's Services Group in 2021/22 and this current review placed reliance on that previous work. We looked to ensure that the systems reported as being satisfactory at that time continue to be so, but more specifically we looked at risk management processes within the Health Visiting and School Nursing Departments and their interface with those of the Women and Children's Services Group.

1.5 The risks associated with our review are as follows.

- The Service Group is not appropriately governed which could result in a service that is not being delivered safely and effectively;
- Risks materialise as they have not been identified and / or addressed;
- Reduced service provision / additional costs due to inappropriate or unauthorised absence;
- Staff performance is not effectively assessed and addressed; and
- Potential loss of financial resources.

1.6 The Lead Executive for this review is the Executive Director of Primary, Community and Mental Health.

2. Detailed Audit Findings

Objective 1: Governance Arrangements

2.1 The Women and Children's Services Group has a current, fully documented organisational structure in place. It outlines the risk and governance informational flow that cascades and escalates into and out of the monthly Women and Children's Services Group Senior Clinical Leadership Team meeting, that provides oversight and scrutiny across all Group departments.

2.2 The Women and Children's Service Group Senior Clinical Leadership Team (SCLT) has a Terms of Reference (ToR) that is current, and meetings are quorate and well attended by its membership.

2.3 There is also a monthly Children's Nursing Quality Governance Group meeting which oversees risk and governance issues relating to the Health Visiting and School Nursing Departments whose key outcomes are then reported into the SCLT. This Group also has a current ToR and its meetings are also quorate and well attended by its membership.

2.4 The Health Visitor and School Nursing departments are formally structured according to region and are led by a Team Leader who holds monthly team meetings with their staff. Our review evidenced how key issues arising from these meetings feed into the Children's Nursing Quality Governance Group meetings.

Conclusion 1:

2.5 Appropriate governance structures are in place with clear reporting lines that support the key operational functions of workforce, risk management, financial management and quality & patient safety within the Women and Children's Services Group. Operational groups within the governance structure are operating effectively with approved Terms of Reference, Agendas, and work plans to provide assurance on key objectives and risk areas. We have provided substantial assurance against this objective.

Objective 2: Workforce Management

Objective 2a: Sickness Absence is appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work policy.

2.6 Team Leaders are responsible for the undertaking of Return To Work Interviews as soon as is practicable upon a member of staff's return to duty (given the nature of their respective roles this may not be on the first day back). As part of this process discussion is undertaken and formally documented relating to any sickness absence prompts ('triggers') that may have been breached.

2.7 Our testing identified two instances of Return-to-Work Interview Forms not being completed within the School Nursing North Team, and a Return to Work Interview Form was not signed off by the School Nursing North Team Leader and the respective member of staff (*Matter Arising 1 – Low Priority*).

2.8 Monitoring and discussion of breaches of sickness absence prompts ('triggers') is undertaken as part of the weekly Health Visiting and School Nursing Team

Leaders meeting held with the Head of Children's Public Health Nursing and Paediatric Services.

2.9 The Workforce and OD Department also run off monthly ESR sickness absence prompt reports that their Workforce advisors review and follow up, liaising with Team Leaders to discuss issues and ensure they are appropriately applying the All-Wales Sickness Guidance process.

2.10 Team Leaders are responsible for maintaining contact with and monitoring the wellbeing of any staff who are on Long Term Sickness absence, and ensuring that this process is documented accordingly, and where appropriate the Occupational Health Department are involved. Our testing identified that this is being undertaken.

2.11 The Head of Children's Public Health Nursing and Paediatric Services provides a monthly update of Health Visiting and School Nursing sickness levels to the Assistant Director of Women's and Children's Services. This forms part of the verbal sickness management update provided to the monthly SCLT meetings as a Standing Agenda item. Additionally, Women and Children's Services sickness data as a whole is reported to the Board via the Group's quarterly Performance Reports.

Conclusion:

2.12 The majority of sickness absence within both Health Visiting and School Nursing departments is being appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work Policy requirements. However, Team Leaders should ensure that all Return to Work Interview Forms are completed in full and as soon as is practicable.

Objective 2b: Annual Leave is appropriately planned, requested, recorded and authorised

2.13 Our review of annual leave processes within the Health Visiting and School Nursing departments identified that all annual leave entitlements at the start of the 2022/2023 financial year were correctly calculated in accordance with service length and employment contract terms.

2.14 All annual leave approval is subject to ensuring that too many staff are not off at the same time, and that mutually and equitably agreed coverage is provided to maintain service provision.

2.15 Team Leaders monitor their staff annual leave balances on a periodic basis to ensure they are taking leave and will remind all staff to ensure that annual leave is taken before the end of the financial year.

2.16 The Assistant Director of Women and Children's Services also periodically reminds management attending the SCLT of the need to ensure that staff take their annual leave by the financial year end.

Conclusion:

2.17 Annual leave within the Health Visiting and School Nursing department is correctly calculated, appropriately planned and requested in accordance with Health Board Annual Leave Policy requirements.

Objective 2c: The PADR and Pay Progression process is actively monitored and managed.

2.18 Each Team Leader within the Health Visiting and School Nursing departments is responsible for the undertaking of PADRs and Pay Progression review for staff within their respective locality.

2.19 All Team Leaders within Health Visiting and School Nursing receive automatic ESR notifications on a regular basis prior to a member of staff's annual PADR due date. The Workforce and OD Department also provides a monthly ESR Business Intelligence Report that outlines those staff that are non-compliant. PADRs are arranged at a mutually agreeable time between the Team Leader and staff member so as not to impede on service delivery.

2.20 Each Team Leader discusses their PADR compliance rates as part of their monthly meeting with the Head of Nursing, Children's Services. A PADR compliance progress report including Health Visiting and School Nursing outcomes is also a standing Agenda item at each monthly Women & Children's SCLT meeting.

2.21 The target monthly rolling compliance rate for the Women and Children's Services Group and each of its constituent Departments is 85%. It is noted that the Group's overall PADR compliance rate in October 2022 was 81% as formally reported to the Executive Team at that time. However, the Auditor acknowledges that PADR compliance trajectory recovery plans are in place within the Group and the Workforce and OD Department to increase the levels of compliance going forward into 2023 and financial year 2023/24.

Conclusion:

2.22 PADR and Pay Progression Reviews are being monitored and undertaken in a systematic manner by Team Leaders at both Health Visiting and School Nursing departments, and their compliance rates and those of the Women and Children's Services Group as a whole are regularly reported to Women & Children's SCLT and Executive Team respectively.

Objective 2d: Statutory & Mandatory Training compliance is actively monitored and managed

2.23 Each Team Leader within the Health Visiting and School Nursing departments is responsible for the oversight of staff within their respective locality to ensure that they are up to date with their Statutory & Mandatory Training.

2.24 Given the role and nature of the Health Visiting and School Nursing departments availability/access to ESR to undertake online training is limited. There is also currently no 'protected'/dedicated time given that allows staff to undertake

Statutory & Mandatory Training in a focussed and unhurried way. (*Matter Arising 2 – Low Priority*).

2.25 Statutory & Mandatory Training compliance rates are documented via a monthly ESR Business Intelligence Report provided to the Team Leaders by the Workforce and OD Department that outlines those staff that are non-compliant.

2.26 Each Team Leader discusses their Statutory & Mandatory compliance rates as part of their monthly meeting with the Head of Nursing, Children's Services. A compliance progress report, including Health Visiting and School Nursing outcomes, is a standing Agenda item at each monthly Women & Children's SCLT meeting.

2.27 As with PADR compliance, the monthly rolling Statutory & Mandatory Training compliance rate target is 85%. The Women & Children's Services Group overall compliance rate in October 2022 was 82%, as formally reported to the Executive Team. As previously stated, the Auditor acknowledges that compliance trajectory recovery plans are also in place to increase the levels of Mandatory Training into 2023/24.

Conclusion:

2.28 Statutory & Mandatory training compliance is actively monitored and managed by Team Leaders and reported on a regular basis to the Women & Children's SCLT meeting and Executive Team. However, compliance rates could be further increased, and knowledge bases improved through the provision of dedicated time to undertake the online training.

Conclusion 2:

2.29 Effective controls are in place for the management of sickness, annual leave, PADRs and mandatory training and these are being consistently applied in practice. We have provided substantial assurance against the Workforce Management objective.

Objective 3: Risk Management

2.30 The Women and Children's Services Group risk register is current in content and is a standing agenda item at each monthly SCLT meeting.

2.31 Risks identified at local Health Visitor and School Nursing Team level are verbally reported to Team Leaders and are discussed at the monthly Children's Nursing Quality Governance Meetings for consideration for inclusion into the Health Visiting and School Nursing risk register.

2.32 The Women and Children's Services Group risk register and Health Visiting and School Nursing risk register are also reviewed and discussed at the monthly Children's Nursing Quality Governance Meetings and progress updates are documented when applicable.

2.33 Where appropriate, Health Visiting and School Nursing risks are escalated for inclusion within the Women and Children's Services Group risk register.

2.34 Our review of the Women and Children's Services Group risk register and the Health Visiting and School Nursing risk register identified that they are both current in content and the scoring of their stated risks is appropriate. Both risk registers include regularly updated risk action plans.

Conclusion:

2.35 The Women and Children's Services Group and its Health Visiting and School Nursing departments undertake risk management processes in accordance with the Health Board's Risk Management Framework and Toolkit, ensuring that risks are appropriately identified, assessed, recorded, and mitigated or escalated when appropriate. We have provided substantial assurance against this objective.

Objective 4: Financial Management

2.36 The delegated budget holder for the Health Visitors and School Nursing Departments is the Assistant Head of Children's Public Health, but at the time of the audit budgetary responsibilities were held by Head of Children's Public Health Nursing and Paediatric Services.

2.37 The Finance Business Partner and Assistant Management Accountant for Health Visitors and School Nursing discuss with the budget holder on a monthly basis budgetary information and analysis in the form of line by line budgetary variance reports for the two departments They also formally meet on a quarterly basis to discuss content and key issues.

2.38 The Head of Children's Public Health Nursing and Paediatric Services also has Qlikview access to their budgets so as to obtain at a glance real-time information. They confirmed that they are satisfied with the quality of information provided and the budgetary informational content and outcomes are clearly explained by the Finance Business Partner and Assistant Management Accountant.

2.39 The Head of Children's Public Health Nursing and Paediatric Services is satisfied with their own knowledge base relating to the interpretation and application of decision making relating to budgetary information provided. If they are unsure the Accountant and Finance Business Partner are readily accessible to provide support and further explanation if required.

2.40 The Head of Children's Public Health Nursing and Paediatric Services provides a brief update of the financial position to the respective Team Leaders of Health Visitors and School Nursing during their weekly meetings. However, this is for information purposes only relating to expenditure incurred as the Team Leaders are not budget holders.

2.41 The financial position of both Health Visitors and School Nursing budgets are presented to and discussed at each monthly SCLT meeting by the Finance Business Partner.

Conclusion:

2.42 Appropriate financial budgetary management monitoring and reporting arrangements are in place within the Women and Children's Services Group in respect of the Health Visiting and School Nursing Departments that align with the requirements of the Health Board's scheme of delegation. We have provided substantial assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Completion of Return to Work Interview Forms (Operation)	**Impact**
Testing undertaken on Sickness absence management relating to both short term and long-term sickness within all School Nursing, Flying Start Service and Health Visitors Teams, confirmed that it is being managed and recorded efficiently and effectively in accordance with the All Wales Sickness Absence Guidance requirements. However, testing identified that within the School Nursing North Team two Return to Work Interview Forms had not been undertaken and one Return to Work Interview Form was not signed off by the Team Leader and member of staff.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

	Recommendations	**Priority**
1.1	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.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1.1	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.	Ongoing	Louise Turner, Assistant Director of Women's and Children's Services

Matter Arising 2: Dedicated/Protected Time for Statutory & Mandatory Training	Impact
Our discussion with each of the Team Leaders within Health Visiting and School Nursing identified that their staff currently have no dedicated or 'protected' time to undertake online ESR Statutory & Mandatory Training due to the role and nature of their work. Whilst Statutory & Mandatory Training completion rates as of October 2022 for all five Teams ranged between 74% and 87% the target rolling monthly compliance rate for the Women and Children's Service Group and each of its constituent departments and teams is 85%. Additionally, within the context of their work locations there is also little or no access to ESR through which the online training could be completed.	Staff performance is not effectively assessed and addressed.

Recommendations		Priority
2.1	Management should consider the implementation of dedicated or 'protected' time for Health Visiting and School Nursing staff to undertake online ESR Mandatory Training. This would help to maximise compliance rates as well as efficiently allow for focussed and relaxed study of the online materials which would further retention of knowledge.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	Time to manage Statutory and mandatory training requirements is managed in line with clinical responsibilities within the service group this is managed at a local level. We are unable to commit to regular days or times to do this as we have to balance the clinical needs of the service.	Complete	Louise Turner, Assistant Director of Women's and Children's Services

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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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Machynlleth Hospital Reconfiguration Project

Final Internal Audit Report

December 2022

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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Distribution:	Wayne Tannahill, Assistant Director of Estates & Property Louise Morris, Head of Capital James Quance, Interim Board Secretary
Committee:	Audit, Risk and 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.

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Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Machynlleth Reconfiguration project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

This was the third audit of the project and considered the period from January to October 2022.

Overall Audit Opinion and Overview

Reasonable assurance has been determined at this review.

The project operated within a robust governance framework during the period, with reasonable controls evidenced in areas including valuation and payments. Initial preparations for commencing the commissioning and handover stages were also evidenced.

The forecast outturn cost remained within budget, and whilst noting the project is delayed by a total of 13 weeks from the original contractual completion date (6 weeks applicable to this audit period) risks to operational delivery are considered minimal.

The key matters arising at the project are:

- the need for consistent inclusion of the cost report within Project Board papers, to enable the forum to fulfil its role as per the terms of reference; and
- the need for a project-specific scheme of delegation, to ensure compliance with Standing Orders.

Other recommendations are within the detail of the report.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2021/22

Assurance summary [1]

Assurance objectives		Assurance
1	Follow up	Substantial
2	Governance	Reasonable
3	Valuation & Payments	Substantial
4	Change Management	Reasonable
5	Performance Management	Reasonable
6	Commissioning	Substantial

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
MA1.1	The need for consistent inclusion of the cost report within Project Board papers, to enable scrutiny in line with the terms of reference.	2	Operation	Medium
MA2.1	A formally approved project-specific scheme of delegation is required for future major projects.	4	Operation	Medium

Introduction

1.1 This audit reviewed the delivery and management arrangements in place to progress the Machynlleth Reconfiguration project (the project).

1.2 The project presents an opportunity for the Powys Teaching Health Board (the THB) to reshape the way community health and well-being services are delivered; with the integration of primary care services and clinical reconfiguration to establish a community well-being hub to improve access to health & social care, wellbeing, prevention, and health promotion facilities.

1.3 Works commenced on site in May 2021. Following discovery of unforeseen issues during the early demolition works the project costs increased significantly. The THB allocated an additional £349k to the project (from discretionary funds), increasing the total budget to £13.455m.

1.4 At the latest Project Board update (October 2022), a forecast completion date of 6 February 2023 was reported, against the current contractual completion date of 23 December 2022 (i.e., a 13 week delay from the original contract completion date, and a 6 week delay from the extended contract). The cost position was reported as follows:

	Approved budget	Current forecast outturn	Variance
Construction works [A]	£10,494,019 [1]	£11,759,417	-£1,265,398
Other project costs:			
THB fees	£244,786	£322,308	-£77,522
THB other (equipment, art, land purchase)	£430,000	£377,737	£52,263
Costs expended against original FBC	£930,571	£930,571	£0
Additional Decarbonisation funding	£227,051	0	£227,051 [2]
Total other project costs [B]	£1,832,408	£1,630,616	£201,792
Total project costs [A+B]	**£12,326,427**	**£13,390,033**	**-£1,063,606**
Contingency balance (inc. THB discretionary contribution of £349k) **[C]**	£1,129,000	£0	£1,129,000
Total [A+B+C]	**£13,455,427**	**£13,390,033**	**£65,394** [3]

[1] *The figure approved in the FBC was subsequently reduced slightly through further analysis and market testing, to reach the agreed £10.316m contract price.*

[2] *Decarbonisation costs included in the construction work total.*

[3] *Residual value of the contingency balance after addressing the variances forecast in project costs.*

1.5 This was the third audit of the project, with the prior two audits both determining reasonable assurance. The audit focused on the period from January 2022 onwards (i.e., subsequent to the period reviewed in the 2021/22 audit).

1.6 The potential risks considered at this review were as follows:

- The THB fails to address known risks identified at prior audits;
- Failure to achieve key project objectives (e.g., delivery to time, cost, and quality);
- Inadequate governance and approval arrangements in place to provide the required scrutiny and project control;
- Time, cost and / or quality are adversely affected by key decisions that were not subject to appropriate approvals;
- Costs agreed with the contractor do not demonstrate value for money;
- Poor performance adversely effecting project delivery; and
- Insufficient readiness for handover.

1. Project Performance

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives (time, cost, and quality) and that governance, risk management and internal control arrangements within the areas under review are suitably designed and applied effectively.

2.2 At this audit of the project, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 A total delay of 13 weeks has been reported from the original completion date, as follows:

- The contractual completion date was extended by 7 weeks from 7 November 2022 to 23 December 2022, including a 5-week delay following the discovery of the well (as reported in the 2021/22 audit report); and
- A further 6-week delay to practical completion, now forecast for 6 February 2023, due to the contractor's difficulties in securing the trades needed to complete the programme – the main contractor has suggested that current market pressures and the rural location of the project site are contributing factors to the delay.

2.4 The current delay does not pose any significant risks to the THB: the GP practice can remain within its current premises until later in the year (when the lease expires), and THB staff are already located elsewhere at the hospital.

Cost

2.5 As at para. 1.4, the project remains within budget, with £65,393 contingency remaining in October 2022. Noting the forecast outturn includes anticipated costs not yet incurred, this may afford the return of monies to the THB's discretionary capital programme.

2.6 The only additional costs incurred as a result of the above mentioned 6-week delay to practical completion relate to additional adviser fees arising from programme prolongation, with these already incorporated into latest cost report figures (see table at para. 1.4). At the time of reporting, the practical completion date remains sufficiently far-off from year-end to not pose a risk of slippage of the Capital Resource Limit.

2.7 Noting the current reported delays to practical completion, the contract does not provide for Liquidated and Ascertained Damages (see the 2021/22 audit report), which may have offset the additional costs being incurred (e.g. adviser fees).

Quality

2.8 The THB has robust quality assurance mechanisms in place, with routine site inspections and receipt of a monthly Supervisor report and monthly health and safety report. Some repeat health and safety issues (not considered significant by the THB) have been noted on site in the last few months, with an action plan in place to monitor improvements.

The following section of the report outlines key observations which require management attention, with low to moderate impact on residual risk exposure until resolved.

2. Detailed Audit Findings

Follow Up: Assurance that previously agreed management actions have been implemented.

2.9 The status of actions arising from the previous review (report issued April 2022: *Reasonable Assurance*) was as follows:

	High	Medium	Low	Total
Closed	-	3	1	**4**
Partially Implemented	-	1	-	**1**
Superseded	-	1	-	**1**
Future Assurance	1	1		**2**
Total	**1**	**6**	**1**	**8**

2.10 The detail in support of the above summary is included in **Appendix B.**

2.11 Two recommendations are for future assurance (i.e., cannot be actioned at this project), and have not been taken into account when considering the assurance rating. Therefore, recognising the actions taken to date, **substantial assurance** has been determined.

Governance: To ensure that appropriate governance arrangements were in place for the current project phase, including the operation of effective reporting and accountability lines, and that appropriate approvals were in place.

2.12 Governance arrangements have continued to function as previously reported, with key forums operating effectively, including:

- Monthly Client Progress Team and Operational Sub-Group meetings;
- Monthly Project Board chaired by the Senior Responsible Officer; and
- The Innovative Environments Group, which meets quarterly and receives routine updates from the Project Board.

2.13 Roles and responsibilities continued to operate as expected, with clear visibility from the Senior Responsible Officer, Project Director, and internal Senior Project Manager. Wider Project Board attendance had improved from the previous review period, with only one of seven meetings reviewed identified as non-quorate (and noting no decisions were taken at this meeting).

2.14 The Project Board received a number of reports as standing agenda items during the period, including the External Project Manager's update, Supervisor's report and the health and safety report.

2.15 Whilst recognising that the overall budget position is presented to Project Board within the External Project Manager's report (as extracted from the most recently available cost report), and the cost report was subject to detailed scrutiny within the project team, it was noted that the timing of reporting did not always permit the Project Board to receive and review the detailed financial information contained within cost report in accordance with their expected duties established within the terms of reference (**MA1**).

2.16 Recognising the above, **reasonable assurance** has been determined in respect of governance arrangements.

Valuation & Payments: Assurance that adequate processes and procedures were in place to ensure that the contractor was correctly reimbursed in accordance with the contract.

2.17 The NEC Option A form of contract has been applied at this project, being a priced contract with activity schedule i.e., each activity is allocated a price and interim payments are made against the completion of each activity.

2.18 The August 2022 valuation was reviewed at this audit:

Valuation date	In-month assessment	Cumulative assessment
August 2022	£595,928	£9,031,806

2.19 The valuation had been assessed by the Cost Adviser in line with the contract requirements and certified for payment in a timely manner.

2.20 Five certifications were reviewed for timeliness of payment. Three were paid in accordance with the contract terms, with minimal delays (no more than 3 days) noted for two. Recognising significant improvement from the timescales observed in our previous audit, no recommendation has been made.

2.21 At the date of fieldwork, the Project Bank Account (PBA) had still not been implemented, with final documents awaiting signature. Progress was being monitored by the Project Board, recognising the intention to bring this into use before the end of the project. Whilst noting the time being incurred to conclude this, the timescales are in line with those experienced at other Health Boards. Even if the PBA is not in place by project completion, the process will prove a useful learning experience for the next major project to be delivered by the THB.

2.22 Noting the above, **substantial assurance** has been determined in this area.

Change Management: Assurance that appropriate internal and contractual change control mechanisms were applied at the project.

2.23 Seven Compensation Events (CEs) were reviewed, totalling £458,489 (representing 54% of total agreed changes since the prior review period). All changes were appropriately substantiated and had been subject to scrutiny and adjustment (where required) by the Cost Adviser. THB approval was granted ahead of instructing the associated works - an improved position from last year's audit findings (see ***Appendix B, recommendation 2.2***).

2.24 However, it was noted that five of the seven CEs had been authorised by the Project Director outside of the THB's Standing Orders (Scheme of Reservation & Delegation of Powers). A project-specific scheme of delegation, granting authority to the Project Director to approve variations within the approved budget, was not identified (**MA2**).

2.25 Where CEs had been discussed at Project Board, the associated minutes were not clear as to whether an approval had been granted at the forum (**MA2**).

2.26 Whilst noting the non-compliance with the THB's Standing Orders, the risk was mitigated by reporting the increased costs (and associated budget implications) to the Project Board. **Reasonable assurance** has therefore been determined in this area.

Performance Management: Assurance that adequate performance (in accordance with appointment/contract conditions) is demonstrated for externally appointed parties e.g., contractor, project manager, cost adviser, supervisor etc.

2.27 Key Performance Indicators had been appropriately completed for the period for the main contractor and advisers, with no performance issues noted.

2.28 Monthly reports have been received from both the Supervisor and the health and safety consultant. Some health and safety issues have been identified - these were reported as 'red-rated' due to their recurring nature, rather than their individual significance. An action plan was in place to address these issues, reported to the Project Board, and showed improvement in the latest reporting period. However, improvements were still required in some areas.

2.29 Recognising improvements still required in the contractor's site health and safety practices, **reasonable assurance** has been determined in this area.

Commissioning: Assurance that appropriate processes were in place to manage the technical and operational commissioning stages, including equipping arrangements.

2.30 The contractor's 12-week completion countdown was launched on 6 October 2022, with a detailed workshop presented to key THB representatives, including the Capital project team, Estates and Support Services (and observed by Audit). The workshop clearly set out how the technical commissioning and handover process would be operated by the contractor, in line with their standard approach, and the inputs required from the THB and external parties (e.g., NWSSP SES) as part of the witnessing and testing process. Work has now commenced to develop detailed supporting programmes and procedures.

2.31 Operational (occupation) commissioning activities will be managed by the internal Senior Project Manager and communicated via the Operational Sub-Group. Equipment schedules were being updated at the date of fieldwork (indicating current costs are within the FBC budget allowance), and training lists prepared to co-ordinate with the 12-week countdown.

2.32 Recognising the operational commissioning process will draw on staff from various departments and include a number of activities requiring coordination delivery at critical points, best practice recommends that an overarching THB commissioning plan would be beneficial to facilitate coordination, monitoring, and reporting (**MA3**).

2.33 Recognising the above, **substantial assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Cost Reporting (Operation)	**Impact**
The Project Board Terms of Reference includes the following financial responsibilities: *"Ensure that the Project Budget is managed and controlled and remains within agreed delegated limits.* *Apply scrutiny of the Project.* *Ensure Powys Teaching Health Board, Shared Services Partnership and Welsh Government officials are informed in a timely manner of any material changes, concerns or issues that are likely to impact on agreed budgets or the achievement of anticipated targets and project delivery."* For the period reviewed (April to October 2022), the Cost Report was only included in advance in the agendas for three meetings (May, June, and July). It is recognised that the cost report was issued only 20 minutes before the October meeting – thus not permitting sufficient time for review. Whilst the Project Manager's report (included in all agendas) presents a high-level summary of the project's financial position, this does not include the supporting information included in the cost report, which would enable more detailed scrutiny.	Potential risks of: • The Project Board is not able to fulfil its full range of responsibilities. • Cost information is not subject to appropriate scrutiny.

Recommendations		**Priority**
1.1	Cost 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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Client appointed Cost Advisor cost reports will be provided for review in advance of Project Board meetings to enable full and appropriate scrutiny.	December 2022 Project Board onwards and at future projects	Project Director

Matter Arising 2: Change Management – Delegated Authority (Operation)	**Impact**
Section 15G of the THB's Standing Orders (Scheme of Reservation & Delegation of Powers) state: *"The Director of Finance shall issue procedures governing the financial management, including variations to contract of capital investment projects and valuation for accounting purposes."* These procedures have been defined in the Standing Orders as follows (table 15G1):	Potential risks of: • Non-compliance with Standing Orders.

Delegated authority	Variations to Discretionary Schemes	Variations to Capital Schemes funded by WG (within Approved Sum)	Financial monitoring and reporting responsibility	Enter lease arrangement (all types) total value
Up to £25k	Associate Director of Capital & Estates (and reported to CEIB)	Associate Director of Capital & Estates	Associate Director of Capital & Estates and Head of Financial Services	Director of Finance and IT
Up to £50k	Associate Director of Capital & Estates (and reported at CEIB)	Associate Director of Capital & Estates	Director of Finance and IT	
Up to £100k	Chief Executive through CEIB	CEO and Director of Finance and IT	CEO and Director of Finance and IT	
Over £100k	Performance & Resources Committee All changes over £100k also need to	Associate Director of Capital & Estates and CEO/ Deputy CEO All changes over £100k also need to be reported to CEIB and Performance & Resources Committee		

An alternative project-specific scheme of delegation was not identified. The Associate Director of Capital & Estates (the Project Director), therefore, has authority to instruct variations up to £50k in value, within the approved sum, at this project.

A sample of seven CEs was reviewed against the requirements of the Standing Orders, with the following observed:

CE no.	Value	Approved by	Approved in line with the THB's delegated limits?
11	£75,403.70	Project Director	N
16	£87,034.96	Project Director	N
24	£108,529.16	Project Director	N
25	£60,023.74	Project Director	N
30	£105,317.36	Project Director	N
38	£4,508.96	Project Manager	Y
48	£17,671.42	Project Director	Y

It is recognised that the Project Board were sighted on these significant variations, and associated budget implications, ensuring appropriate monitoring and scrutiny of the cost increases. In one case (CE30), email correspondence reviewed confirmed that the Project Board had been involved in the approval of the variation – however, this was not documented in the associated minutes (also noting the role of the Project Board in approval of variations is not defined in the Standing Orders).

It is noted that this matter has not been raised at prior audits of the project - earlier changes reviewed fell within the Project Director's delegated authority.

Recognising the limited contingency funds available for completion of this project, there is minimal opportunity for the delegated limits to be exceeded again by the Project Director. The THB should therefore consider a project-specific scheme of delegation in readiness for delivery of the next major capital project. Until the same is formally approved, the Standing Orders should be complied with.

It is also recognised that a previous recommendation has been made (see Appendix B, MA3.2a) in relation to timeliness of contract execution. Management have advised this will be considered as part of a wider project governance review in consultation with the Director of Finance and the Board Secretary. Therefore, we have included the previous recommendation in this table for ease of future reference.		
Recommendations		**Priority**
2.1a	All project variations should be approved in line with the Standing Orders.	**Medium**
2.1b	Where the THB wishes to vary the delegated financial limits contained within the Standing Orders, a project-specific scheme of delegation should be defined and formally approved at an appropriate level for application at future projects.	
2.1c	Noting timeliness of contract execution is a recurring audit recommendation at the THB, management should develop an acceptable procedure to facilitate the signing of agreements / contract documentation in a complete and timely manner.	
2.2	Project Board minutes should clearly record when a decision is made/approval granted.	**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1a Agreed	Immediate	Project Director

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2.1b	Project-specific scheme of delegation will be considered / implemented, dependent on value of project, to administer variations whilst still maintaining the governance criteria for overall cost control for future major projects.	January 2023 for application at future projects	Project Director, in consultation with the Director of Finance and the Board Secretary.
2.1c	Strengthening of process to ensure timeliness of signing of agreements / contract documentation will include investigation of electronic signatures and possible delegation of authority for signing of construction related contracts.		
2.2	Project Board minutes will clearly record decisions made and approvals granted.	December 2022 onwards	Project Director

Matter Arising 3: Operational (Occupation) Commissioning (Operation)	**Impact**
The Capital Investment Manual (CIM) sets out the importance and complexity of the operational (occupation) commissioning process, which can often be underestimated. The appropriate management of this stage will ensure a smooth transition to operation of the new facility and support the realisation of the intended benefits. To coordinate the key activities required during this stage, CIM recommends the development of a 'Commissioning Masterplan' which should: • identify key dates for occupying or bringing the facility into use. Where many functions are concerned, this may have to be undertaken on a phased basis over time; • identify key tasks in the occupation and transfer process and identify clearly where the responsibility for these lies; • identify a critical path for an integrated transfer of functions addressing clinical need and functional interdependencies; • identify key dates for selecting and ordering equipment and artwork; • identify any closures and arrangements for security and disposal of sites if relevant; • ensure that there is little or no disruption to patient services; and • identify a staff recruitment, transfer, and counselling programme. The Senior Internal Project Manager is responsible for managing the operational (occupation) commissioning process. From audit review, and observation at the October Project Board, it was clear that the key activities had been considered and were in hand. However, a 'masterplan,' as above, was not identified. This would support the management, monitoring, and reporting to Project Board of progress during this key stage.	Potential risks of: • Failure to achieve the planned operational date. • Reduced ability to report progress to Project Board.

Recommendations		Priority
3.1a	An operational (occupation) commissioning plan should be developed.	**Low**
3.1b	The Project Board should receive routine updates on progress against the operational commissioning plan.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Formal operational commissioning masterplan will be produced to identify aspects of activity for the health board to successfully occupy the completed facility, to include items highlighted within the Capital Investments Manual.	December 2022	Senior Internal Project Manager
3.1b	Project Board agenda will reflect standing item to receive updates on progress against the operational commissioning masterplan.	December 2022	Senior Internal Project Manager

Appendix B: Follow up of previously agreed management actions

Previous matter arising 2.1: Enabling Works (Operation)	
Original recommendation and management response	Original priority
Future Assurance At future schemes, either: • The SRO should obtain formal written approval from Welsh Government to progress works in accordance with national guidance requirements; or • Board approval to projects proceeding at risk should be obtained in the absence of the former. **Management Response:** Not agreed. PTHB liaised closely with Welsh Government in respect of the anticipated approval of the FBC at the end of 2020 through to actual approval on 24 March 2021. Welsh Government fully funded the additional enabling works, largely seasonal and due to ecology issues (issues which would have had led to delay and consequential costs to the main project had they not been dealt with in a time sensitive manner). Welsh Government gave no indication of risk to any expenditure during this period which may have warranted escalation.	**Medium**
Current findings	**Residual risks**
Recognising the project-specific nature of these recommendations, the position will be re-assessed if a similar situation arises at a future project subject to audit. **Conclusion:** Closed - to be considered at future projects.	N/A

Previous matter arising 2.2: Enabling Works (Operation)	
Original recommendation and management response	Original priority
Compensation events should be assessed and discharged within the stated contractual requirements. **Management Response:** Agreed. Compensation events will be addressed in accordance with the contractual requirements.	**Medium**
Current findings	**Residual risks**
From the sample of seven CEs (totalling £458,489) reviewed in this year's audit, all but one had been approved by the THB ahead of the CE being issued and work being undertaken. The one exception (£4,508) related to work undertaken as part of the S278 agreement, with the CE approved on receipt of the invoice. Recognising the nature of this work i.e., essential water work in the highway, assessment/discussion within the THB was not required. Therefore, the recommendation has been closed. **Conclusion:** Closed.	N/A

Previous matter arising 3.1: Contract Execution (Operation)	
Original recommendation and management response	Original priority
Future Assurance Management should ensure that contracts are: • Dated where space is provided within the template. • In place prior to works / duties commencing; and • Executed in accordance with the THB's delegated authority limits. **Management Response:** Agreed.	**High**
Current findings	**Residual risks**
Contract execution will be considered at future projects, where appropriate. **Conclusion:** Closed - to be considered at future projects.	N/A

Previous matter arising 3.2a: Contract Execution (Operation)	
Original recommendation and management response	Original priority
Noting timeliness of contract execution is a recurring audit recommendation at the THB, management should develop an acceptable procedure to facilitate the signing of agreements / contract documentation in a complete and timely manner. **Management Response:** Agreed.	**Medium**
Current findings	**Residual risks**
Management confirmed options are being considered, including potential for implementing an electronic signature system. However, a solution had not yet been agreed at the time of review. Recognising the current stage of this project (with no further contracts required), this should be addressed in readiness for implementation at all subsequent capital projects. **Conclusion:** Superseded. See Appendix A, MA 2.1c.	N/A

Previous matter arising 3.2b: Contract Execution (Operation)	
Original recommendation and management response	Original priority
The THB's existing checklist / cover document should be enhanced to include a tick box to indicate key contract amendments / risk items included within contract documentation. **Management Response:** Agreed.	**Low**
Current findings	**Residual risks**
The checklist has been split into three proformas (contracts, purchase orders and leases), enabling tailored detail to be added to each. It is noted the checklist has not yet been used for contract approval within the THB, and this will therefore be reviewed at future audits. **Conclusion:** Closed.	N/A

Previous matter arising 7.1a: Risk Register (Operation)	
Original recommendation and management response	Original priority
The External Project Manager should ensure the construction risk register is fully and appropriately costed. **Management Response:** Agreed. Risk Register costing, this was the case at FBC and lapsed for a period during construction phase albeit this was replaced by a robust Contingency Tracker which was the mechanism by which the issues with structure were raised circa August with flagged circa £180K overspend (circa 1.37% of project value).	**Medium**
Current findings	**Residual risks**
The consolidated risk register now incorporates both construction and PTHB risks. The construction register had been fully costed, with residual risk totalling £68,403 at the time of review. **Conclusion:** Closed.	N/A

Previous matter arising 7.1b: Risk Register (Operation)	
Original recommendation and management response	Original priority
The costed risk register should be reconciled to remaining project contingency. Any insufficiencies identified should be reported appropriately within the THB. **Management Response:** The updated risk register (March 2022) details that the project is operating within contract budget with £162K contingency remaining. The current value is around the original value of the project whilst major concern flagged by Audit, in late 2021 (during fieldwork), was that the contingency had been largely expended in the front end of the project. It is contended that this is always where the contingency comes under pressure as this is where demolitions and groundworks (unforeseen) are undertaken. It is evident that the Audit concern has not come to fruition as some 6 months after the audit concern, the financial position remains around £180K over the original contract value and it should be noted that the current risk value also includes £50K for legislative change and £130K for un-concluded design, which may not be expended.	**Medium**
Current findings	**Residual risks**
The external Project Manager's progress report incorporated consideration of the contingency and financial risk position of the construction risk register. The October 2022 report (shared with the Project Board) highlighted a forecast underspend / remaining contingency of £54,283, slightly lower than the residual construction risks (£68,403). **Conclusion:** Closed	N/A

Previous matter arising 7.1c: Risk Register (Operation)	
Original recommendation and management response	Original priority
The development of the THB risk register should be finalised, ensuring key details such as risk owners (including those defined within the Construction Delivery Agreement), mitigating actions, and associated costs (where appropriate), are captured. **Management Response:** Agreed. The Head of Capital has consolidated and updated the risk register accordingly.	**Medium**
Current findings	**Residual risks**
The THB risk register had been further developed at the time of review, in line with the recommendation. Room for further enhancement was noted, however, as follows: • Risk ownership has been detailed as simply the THB or the Contractor. For ease of monitoring and management, named individuals within the THB should be recorded wherever possible; and • The costed risk figures required updating to reflect the current reported position. Whilst costed risks (including both THB and construction risks) totalled £185,140 (exceeding remaining contingency), it is anticipated that this variance will reduce on review. Once the risk register has been updated, any variance between total costed risks and remaining contingency should be highlighted to the Project Board. Recognising the limited contingency funds remaining to project completion, the timely review and reporting of the risk position is important. **Conclusion:** Partially Implemented.	Project risks may exceed available contingency funds.

Recommendation		Priority
The THB risk register should be reviewed and updated, with any variance between costed risks and remaining contingency highlighted to the Project Board. The register should also be updated to included named individuals, as risk owners, where possible.		**Medium**
Management response	**Target Date**	**Responsible Officer**
Risk Register will be reviewed with any costed risks linked to contingency for consistency. Named individuals will be included where possible as risk owners.	November 2022	Head of Capital

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives (time, cost and quality) and 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.
 **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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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North Powys Wellbeing Programme
Final Internal Audit Report

December 2022

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

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Executive sign-off:	Hayley Thomas, Director of Primary, Community & Mental Health.
Distribution:	Stephen Powell, Director of Planning and Performance Carly Skitt, Assistant Programme Director Emma Peace, Change Manager - Wellbeing
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

An assessment of the health board's arrangements to take the North Powys programme forward. To include focus on the management of demand and capacity modelling and service mapping.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Programme and critical path require updating.
- A standardised workbook was not used for the monitoring of the Ophthalmology Project for 22/23 financial year.
- Programme risk register requires a deep dive and outliers to the risk appetite should be adequately treated.
- The benefit and outcome framework and service mapping needs updating.

Other recommendations / advisory points are 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	Approved business case(s) and programme initiation documents are in place.	Substantial
2	Detailed Programme plan(s) and work stream(s) are in place to proactively carry out and coordinate timely delivery of the NPWP.	Reasonable
3	Adequate systems are in place for the monitoring of ongoing delivery of the NPWP and associated accelerated programmes.	Reasonable
4	Adequate processes are in place for demand and capacity modelling and service mapping.	Reasonable
5	Appropriate governance arrangements are in place for the overall programme and associated accelerated programme(s).	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	Programme Plan	*2*	Design	High
2	Review of Workstream Plans and Project Workbooks	2	Operation	Medium
4	Risk Register Review	3	Operation	Medium
5	Benefit and Outcome Framework	3	Design	Medium
6	Service Mapping Update	4	Design	Medium

1. Introduction

1.1 The review of the 'North Powys Wellbeing Programme' was completed in line with the Powys Teaching Health Board's (the 'health board') 2022/23 Internal Audit Plan. The audit was originally included as a part of the Health Board's 21/22 plan, this did not take place as a result of the pressures faced by the Health Board during the Covid pandemic.

1.2 The 'North Powys Wellbeing Programme' is a form of the new integrated model of care which will include a Regional Rural Centre (to enhance the local service offer) and Community Wellbeing Hub (to improve wellbeing and reduce demand on future service provision) both of which were set out in the Health and Care Strategy. This is a joint programme between the Health Board and Powys County Council on behalf of the Powys Regional Partnership Board (RPB).

1.3 The North Powys Wellbeing Programme was formally launched in May 2019. However, during Covid-19 the Programme was suspended for a short period and when it recommenced it operated under revised governance arrangements with limited resource. A Programme Business Case for a Multi-Agency Wellbeing Campus in Newtown was endorsed by the Welsh Government in March 2022. The Campus will have a strong focus on wellbeing, and early help and support for children and families.

1.4 The Programme was subject to a Welsh Government Performance Assessment Review in July 2021. The review highlighted that the Programme had good leadership but also the need to re-engage since the pandemic, with securing funding and governance amongst the feedback raised.

1.5 The scope of the North Powys Wellbeing Programme includes:

- The testing and delivery of a new integrated model to a rural population which focuses strongly on evidence based of innovative practice to deliver the highest value and efficient system;
- The development of a multi-agency wellbeing campus in Newtown which includes education, housing, health and social care and leisure/wellbeing activities;
- Working with local communities to co-design and address the practical implementation of a new integrated model which is based on future needs, addressing "what matters" to people, has ownership by communities, and builds the capacity of individuals and communities to develop and evolve formal and informal community services that enable people to live independent and healthier lives; and
- Effective learning, evaluation and transfer, acting as a flagship scheme to support the broader roll out of a new integrated model across Powys.

1.6 Acceleration for Change Projects (ACP) are small projects undertaken to help achieve the overall aim of the North Powys Wellbeing Programme. Acceleration for change projects started prior 21/22, some have been completed and others

are work in progress (either carried over from 21/22 to 22/23 or new projects in 22/23) as below.

2021/2022	2022/2023 (WIP)
Bach A Iach- **Completed**	Powys Together
Repatriation of Children Looked After – **Completed**	Ophthalmology
Ophthalmology – **Carried into 22/23**	Digital engagement
Digital Facilitators - **Completed**	Community Training Platform
Community Training Platform – **Carried into 22/23**	
Respiratory – MDT - **Completed**	
Respiratory – Spirometry - **Completed**	
Respiratory – Sleep Apnoea – **Completed**	
Powys Together – **Carried into 22/23**	

1.7 The Director of Primary, Community & Mental Health is the Senior Responsible Officer (SRO) for the North Powys Wellbeing Programme and will therefore be the Executive lead for this review.

Audit Risks

1.8 The potential risks are:

- Poor and / or inefficient delivery of the Programme;
- Exposure of Health Board to reputational damage and disruption of services provided to patients; and
- Ineffective governance arrangement due to a lack of appropriate structures and reporting lines.

2. Detailed Audit Findings

Objective 1: Approved business case(s) and programme initiation documents are in place, and they reflect a clear and controlled process for defining the overall objective of the North Powys Wellbeing Programme.

2.1 The North Powys Wellbeing Programme was established in 2018, and formally launched in June 2019.

2.2 The Programme was paused at the start of the pandemic (March 2020 into 20/21) but had restarted with Board approval for the Programme Business Case in November 2020.

2.3 A programme mandate was approved for the Welsh Government (WG) funding bid by the programme Board in 2019. Given the current stage of the Programme, the Programme Mandate serves as a Project Initiation Document. The programme

was funded through the transformational funding which was subsequently approved by the WG for 2 years ending March 2022. The programme is currently funded through the Regional Integration Fund (RIF).

2.4 The North Powys Wellbeing Programme Business Case (PBC) was approved by the Health Board in October 2020, in readiness for submission in November 2020 to the WG. This was later approved in March 2022 by the WG.

2.5 A Strategic Outline Business Case (SOC) for the Health, Care, Supported Living and Infrastructure was produced following the submission of the PBC. The SOC was approved by the Health Board, Powys Council Cabinet and the Programme Board. It was also endorsed by the RPB and submitted to the WG for approval in March 2022. They are currently awaiting the WG approval of the SOC.

2.6 There is also a separate SOC for Education document which is external and not wholly produced by the Health Board, but is being worked on as a team with the Council as it is managed through the council's 21st Century School Programme.

2.7 The four Acceleration for Change (AFC) Projects selected for review as part of the audit had their business cases approved by the Programme Board. The selected projects are:

Completed Projects

- Bach A Iach
- Respiratory- Multi Disciplinary Team (MDT)

WIP Projects

- Ophthalmology
- Digital Engagement

Conclusion:

2.8 Documentations required to initiate and commence the relevant phases of the Programme were maintained. Adequate scrutiny and approvals were undertaken by the required parties. The SOC outlined the key deliverables for the programme which have been adopted in the process. (Substantial Assurance)

Objective 2: Detailed Programme plan(s) and work stream(s) are in place to proactively carry out and coordinate timely delivery of the 'North Powys Wellbeing programme.

2.9 A detailed programme plan was in place for 2021/22 but was formally closed down at the Delivery Team's meeting in May. Development of the detailed programme plan for 2022/23 is however still a work in progress. It is yet to be fully updated for approval and use and the Critical path for 2022/23 is yet to be updated to reflect the Programme's service changes. ***(Matter Arising 1 – High Priority)***

2.10 Workstreams have recently been allocated for the next phase of the programme. They are currently transitioning between phases and are yet to establish or formally launch the workstream phase.

2.11 The acceleration for change projects have individual workbooks. Workbooks have also been developed for other workstreams for this financial year. There are milestone plans within the workbooks segregated on a quarterly basis stating what has been developed per quarter and a performance measure for tracking delivery during the year.

2.12 For the new 2022/23 workstreams there are three major categories (Enabling, Innovative environment and the five transformational areas). The acceleration for change workstream which used to be a part of the core workstream previously has been combined into the enabling workstream.

2.13 At each stage of the Programme, Engagement and Communication plans were developed for both the SOC and the OBC. These Engagement and Communication plans were reviewed to ensure actions as set within the plans were undertaken.

2.14 The workbooks of the four Acceleration for Change projects were reviewed. Some observations have been noted as detailed below and in appendix A. ***(Matter Arising 2 – Medium Priority)***

Completed Projects

1) Bach A Iach:

All anticipated outputs for the quarterly periods were monitored and delivered with an overall green RAG rating at the end of the financial year 2021/22.

2) Respiratory- (Multi-Disciplinary Team) MDT:

The monthly reports indicated that respiratory projects as a whole had a Green RAG rating with risk attributed to respiratory MDT's project due to recruitment challenges. It was observed that some datasets were not available at the time of compilation for the Respiratory (MDT) project, thus not reflected in the RAG rating for delivery of plan.

WIP Projects

3) Ophthalmology

This is a project that was carried over from 21/22 to 22/23 financial year. On the whole the project so far seems on track from the measure and target provided within the workbook. The monthly reports highlighted a recruitment issue. There were some findings from the review of the workbook.

4) Digital Engagement:

Overall, the project has an amber rating which is mostly attributed to the recruitment challenge. This aligns with the AFC monthly reports.

2.15 On a monthly basis project leads for all accelerated projects provide updates on the progress made with any escalation required made to the Delivery Team. Some of the monthly updates saw the presentation of the same or very similar information within the reports for subsequent months. ***(Matter Arising 3 – Low Priority)***

Conclusion:

2.16 An effective Programme plan was in place for 2021/22 and the 22/23 Programme plan has been established in draft. However, half-way through the year it is still to be finalised and no timeline has been specified. We did note that the 2021/22 plan was adequately managed through the workstreams, Acceleration for Change projects, Programme lead report, the Programme's and the Health Board's forums, Welsh Government quarterly reporting and annual review. The North Powys Wellbeing programme for 2022/23 has also been monitored using the Programme's lead report. The acceleration for change projects also have their quarterly timelines set within their workbooks with a performance measure section updated quarterly. Other workstreams for the current year will be adopting the use of a workbook for the timely monitoring of their performance activities against the target. (Reasonable Assurance)

Objective 3: Adequate systems are in place (such as the maintenance of programme risk register(s), outcome and benefits framework and other relevant reports) for the monitoring of ongoing delivery of the North Powys Wellbeing Programme and associated accelerated programmes.

2.17 There is an overarching Programme Risk Register with an escalation process feeding into the Directorate risk register. Risks are escalated through the Programme Risk Register, risks can also be escalated to the programme Board via the programme lead report which is presented every month at the Programme Board meetings.

2.18 The programmes risk register was assessed to confirm evidence of review and that it contained required fields. Relevant fields were completed, and updates provided with respective date of review.

2.19 The North Powys Wellbeing Assurance Framework was approved by the Programme Board in June. The framework uses the Health Board's risk appetite and risk management approach.

2.20 In confirming, the adequacy of the systems in place regarding the management of the programme's risk, some observations were made following the reviews below:

- The programmes risk register was assessed;
- Key issues and risks in the programme lead report for June and July were reviewed; and
- Review of risks at the programme delivery team and board meetings.

(Matter Arising 4 – Medium Priority)

2.21 The Acceleration for Change Projects do not currently have individual risk registers, yet relevant risks were reviewed and escalated monthly through the monthly acceleration for change meeting to the Programme's Delivery Team and Programme Board on the Programme's Lead report.

2.22 The Outcome and Benefit Framework was previously developed in 2020 and requires an update. ***(Matter Arising 5 – Medium Priority)***

2.23 A stocktake and risk workshop session took place 26th April 2022, to reflect and consider any learning from the Programme to date for the information of the next phase of work. Key learnings were taken forward via several recommendations which outlined the need for improvement.

2.24 The review of the Programme Board's action log indicates that work is being undertaken to tackle the recommendations from the stocktake report. Recommendations are selected, with an allocated owner and notes with dates stating the position at the time of the meeting.

2.25 Clarity Consulting Associates Ltd (Clarity) were commissioned in February 2020, by the Powys RPB, to undertake an independent evaluation of the North Powys Wellbeing Programme as stipulated by the WG as a condition of receiving Transformation Funding (TF). The evaluation rated the Programme as being Amber with good leadership highlighted but also the need to re-engage since the pandemic, with securing funding and governance amongst the feedback raised.

Conclusion:

2.26 The North Powys Wellbeing programme maintains a risk register which was updated in July; however, it requires a focused review. In addition to the maintained register, there are also reasonable systems in place for monitoring the delivery of the Programme. (Reasonable Assurance)

Objective 4: Adequate processes are in place for demand and capacity modelling and service mapping.

2.27 A high-level health and care demand and capacity modelling exercise was undertaken to support the SOC and determine future demand of health and care services for the population of Powys and quantify current and future capacity requirements. This is being carried out in three phases, currently phase one has been completed. This focused on key areas of service change found on evidenced-based, expert opinion and national best practice.

2.28 The demand and capacity modelling went through scrutinisation by a number of forums such as the Demand and Capacity Modelling Technical Group, clinical and professional groups, Programme Board, Programme Delivery team and Analyst team.

2.29 The baseline year was set out and it was agreed that 2019 was used as the base year. It is the usually the practice to adopt the previous year's data but as a result

of the COVID pandemic it was impractical to use the year 2020 because of the skewed representation.

2.30 Going forward they are proposing to have five technical groups for each of the transformational areas. A modelling coordination group has just been established for the new phase. The business analyst team were responsible for pulling out and putting together the data set off relevant systems while the modeller came up with the baseline data used. The scope of the programme was agreed with the analyst.

2.31 An assumption Framework was built to aid the development of the service model for the North Powys Wellbeing Programme and understand all the assumptions applied to demand projections. The assumptions highlighted six major characteristics with three potential scenarios. Demand was further broken down into agreed planning horizon for modelling which has been confirmed to be years 0, 3, 5, 10 & 20.

2.32 Service mapping was undertaken in 2019, however this requires an update to ensure its continued relevance and applicability. ***(Matter Arising 6 – Medium Priority)***

Conclusion:

2.33 A robust process has been undertaken (at this phase) in the development of the demand and capacity model while the service mapping needs refreshing to mitigate potential issues caused by time and event. (Reasonable Assurance)

Objective 5: Appropriate governance arrangements are in place for the overall programme and associated accelerated programme(s) which provide oversight with clear reporting lines and escalation processes to relevant groups/ committees.

2.34 The governance arrangements for the Programme are flexible and change depending on the focus of what is being delivered at the relevant phase of the Programme. The pandemic led to the Programme operating with revised governance arrangements.

2.35 The North Powys Wellbeing Programme is under the sovereign body of Powys County Council (PCC) and the Health Board, the governance arrangements are delivered under the RPB bringing together partner organisations and other key partners from public sector bodies, the private sector, and voluntary third sector organisations.

2.36 The Programme Delivery Team and Programme Board both have up to date terms of reference in place.

2.37 The Programme Delivery Team met once a month as stated in the ToR, however, based on the current governance framework meetings will be held fortnightly. The Programme Board meets every month.

2.38 The agendas, minutes of meetings and action logs of the Programme Delivery Team and Board were reviewed. Although some minor observations were noted, these groups are operating effectively for the overall governance of the Programme. ***(Matter Arising 7 – Low Priority)***

2.39 The Programme Lead report highlights the RAG status for projects and issues for escalation, it is a key report which provides an overview of the Programme at each period to the Programme Board. This is also made available at the Programme Delivery Team's meetings for information. This report feeds in from information provided in the workstream reports. A revised Programme Lead report was introduced in line with new workstream reporting in July.

2.40 The Health Board is kept informed and updated regarding the Programme through the following mechanisms:

- Planning, Partnership & Population Health Committee (PPPH): The Programme's reporting to PPPH is on an adhoc basis. This forum is usually used for the approval of documents such as the MoU and SOC.
- The Health Board Board: Reports presented at the PPPH committee are also forwarded to the Board.
- Delivery and Performance Committee: The North Powys Wellbeing programme reports to this Committee.

2.41 Under the transformational funding the Programme was required to submit a quarterly report which went via the Programme Board prior to submission to the WG. The final quarterly report made to the WG was in quarter 4 of the financial year 2021/22.

2.42 The Programme alongside the Change Accelerated Programme is now funded by the Regional Integrated funding (RIF) until March 2023. The reporting process for the new funding, will go through the RPB. A financial quarterly update and a 6 monthly update will be required. A template from WG for this reporting was recently received and work is underway in order to fully adopt its use.

Conclusion:

2.43 Overall, the North Powys Wellbeing Programme has a robust governance arrangement system in place. (Substantial Assurance).

Appendix A: Management Action Plan

Matter Arising 1: Programme Plan (Design)	**Impact**
The 21/22 programme plan had milestones allocated into a quarterly timeline. This was closed down in May 2022 with some carried over actions/ milestones. The current year's programme plan (22/23) is currently a work in progress document undergoing reviews at the Programme's Delivery Team and Board meetings. The draft plan highlights milestones/ actions, however, no timeline has been allocated halfway through the financial year. The Critical Path was initially approved in 2021. This is also yet to be updated to reflect the programme's service changes for planning/decommissioning services, recruiting and workforce skills.	Potential risk of: • Poor and / or inefficient delivery of the Programme.

Recommendations		**Priority**
1.1	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.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	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.	31 January 2023	North Powys Wellbeing Programme Senior Responsible Officer (SRO)

Matter Arising 2: Review of Workstream Plans & Project Workbooks (Operation)	**Impact**
Engagement and communication At each stage of the plan an engagement and communication plan was developed for both the SOC and the OBC. 7 descriptions/ actions with the set milestone of quarter 2 22/23 for completion were selected for reviewed. The review found that: • Three of the seven milestones had not been achieved for the period. Acceleration for change Projects 4 Acceleration for Change projects were selected for review, the following observations were made from the review of the Ophthalmology Project: • The milestone tab in the 21/22 workbook was not completed for most of the quarters to indicate if the anticipated output was achieved. • The workbook that was in use at the time of our fieldwork for the 22/23 financial year noted the actual achievement indicators, these had been updated for the first 2 quarters of the year but only stated the indicator measures in figures. It was noted that the workbook for the 22/23 financial year for this project does not contain as much detail as that of the previous year and other current projects. Monitoring information such as the milestones for the period alongside the comment section for actual progress for the quarter were absent. • We were subsequently provided with an updated copy of the outcome indicators workbook which detailed the actual achievement against the targets for the first 2 quarters of 22/23. Patterson,Liz 01/02/2023 09:10:51	Potential risk of: • Poor and / or inefficient delivery of the Programme.

Recommendations		Priority
2.1	Management should ensure there is a standardised and robust system in place for the adequate monitoring of projects.	**Medium**
2.2	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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	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.	31 January 2023	SRO
2.2	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.	28 February 2023	SRO

Matter Arising 3: Acceleration for Change Monthly Report (Design)	Impact
The Acceleration for Change project reports for three months were provided for each of the four selected projects. It was observed that two of the four Projects had the same reports presented for two of the three months and only a slight change in one of the three months reports. This is possibly as a result of minimal changes in status over the one-month period, but this was not clarified within the reports.	Potential risk of: • Risk of ambiguity and misperception.

Recommendations		Priority
3.1	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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
3.1	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.	31 December 2022	SRO

Matter Arising 4: Risk Register Review (Operation)	**Impact**
There were 12 risks in the risk register. On review of the risk register it was observed that 4 of 12 risk targets were highlighted as outliers to the Health Board's risk appetite. Risk Register Format The risk register is managed using both word and excel documents. Excel is used to compute the trend of each risk while the word document is the main risk register. The word document risk register has two parts, the risk register table and the dashboard. In comparing the contents of both parts, we found that both had the same fields and also dissimilar fields. This indicates that the risk register does not contain all the information at a glance. The dashboard should be a representation of the risk register as a whole. All information relevant to-one risk on the risk register cannot be viewed concurrently. Programme's lead report Key issues and risks noted in the programme lead reports for June and July were reviewed to confirm if they had been included in the risk register. It was observed that although the risks were highlighted, they have not been included in the risk register, for example the risk associated with the effect and delay in transitioning to the next phase has not been captured within the risk register as stated (and extracted) from the programme lead report below. Extract of June and July's report states respectively: *June* *'There is a significant risk we are unable to recruit to new posts required to support next phase, Programme Board are asked to DISCUSS and APPROVE the resource paper to minimise this risk.'* *July* *'Transition between stages is resulting in delays to the programme. Programme Plan for next stage prepared with outputs, timescales to be confirmed. Critical path to be reviewed and to consider work being undertaken via IE workstream on infrastructure plan and site phasing.'*	Potential risk of: • Exposure of Health Board to reputational damage and disruption of services provided to patients.

Presentation and review of risks in groups The governance framework requires that the risk register is reviewed on a quarterly basis by both the Programme Delivery Team and Programme Board. Following the risk register score update in early July and subsequent presentation of the risk register at the Delivery Team meeting later that month, it was stated that the risk register still required a detailed review of mitigating actions and deep dive of risks following the stocktake workshop. This deep dive is yet to be undertaken. The review of risk register scores against risk appetite was presented to the Programme Board's meeting in August. This has however been the only review of the risk register by the Board in the 22/23 financial year.	

Recommendations		Priority
4.1	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.	**High**
4.2	As noted at the Programme Board, an informed decision should be reached regarding the management and escalation of outliers to the risk appetite.	**Medium**
4.3	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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
4.1	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.	31 December 2023	SRO
4.2	To be included on a future Programme Board Agenda to discuss a management and escalation plan moving forward	26 January 2023	SRO
4.3	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.	30 March 2023	SRO

Matter Arising 5: Benefit and Outcome Framework (Design)	**Impact**
The Benefit Framework was previously developed as a part of the Programme Business Case in 2020. This was an overarching framework which displayed a high-level outcome of the Programme. Some Acceleration for Change projects have delivery of some of these outcomes while the multi-agency wellbeing campus element of the outcome is still a work in progress. An update to the outcome and benefit framework will bring these elements together. We were informed that a new Regional Integration Funding (RIF) Outcomes Framework has been introduced and templates have been completed for all projects under the North Powys Programme.	Potential risk of: • Working outside the desired and strategic goal of the programme.

Recommendations		**Priority**
5.1	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	31 December 2023	SRO

Matter Arising 6: Service Mapping update (Design)			**Impact**
The Service mapping was undertaken in 2019, this helped to inform the Programme's business case and strategic business case. Following the pandemic, additional work and relevant adjustments are required to decide the service improvement levels required and synchronise the transformational services agenda.			Potential risk of: • Poor and / or inefficient delivery of the Programme.
Recommendations			**Priority**
6.1	The service mapping should be updated to ensure the programme has continuous relevance in providing a clearer picture to services to users, encouraging solidarity of stakeholders especially locals of North Powys accepting change and importantly supporting the required service transformation plan.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	A full review of the service mapping has been carried out and updated and aligned to the 5 transformation areas of work.	30 January 2023	SRO

Matter Arising 7: Governance Arrangement review (Operation)			**Impact**
The new governance framework was approved and updated. As at the time of review, the membership agreement for the Delivery Team was yet to be established because some of the workstream leads were yet to nominate a lead to attend the Programme Delivery Team. Over the 3 months period reviewed one meeting was stood down for both the Delivery Team and the Programme Board. It was also noted that the Delivery Team's meeting held in June was not quorate.			Potential risk of: • Meeting not quorate
Recommendations			**Priority**
7.1	Management should ensure the membership agreement is sorted promptly for the smooth running of the governance framework and the programme as a whole. Management should also encourage key staff to attend their respective programme meetings drawing their attention to the quorate requirement stated in the ToR in the Governance framework.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Majority of work areas have now identified leads from respective organisations who attend Programme Delivery Team on a monthly basis with the exception of the social model for health transformation area.	26 January 2023	SRO

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Charitable Funds
Final Internal Audit Report

December 2022

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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Management response received:	20th December 2022
Final report issued:	20th December 2022
Auditors:	Jayne Gibbon, Internal Audit Manager Geoffrey Woolley, Principal Internal Auditor
Executive sign-off:	Pete Hopgood, Director of Finance and ICT
Distribution:	Andrew Gough, Deputy Director of Finance Sarah Pritchard, Head of Financial Services Abe Sampson, Charity Manager
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 review was to ensure that Charitable Funds were appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The review of the Charitable Funds policy is overdue.
- Regular reports should be issued to each fundholder and discussed with them.
- The Charitable Funds Committee Terms of Reference should be reviewed.
- Enhancements are required for recording donations relating to a single event.
- Improvements are required in the completion of application forms for charitable funds expenditure.

Other recommendations / advisory points are 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	Appropriate guidance is in place covering receipt of income, expenditure, fundraising and investments.	Reasonable
2	Income received is appropriate and accounted for correctly.	Reasonable
3	Expenditure is appropriate, authorised and within the terms of the fund.	Reasonable
4	Funds held are appropriately monitored, managed and invested.	Reasonable
5	Role of Charitable Funds Committee is appropriately defined and provides adequate oversight.	Reasonable

[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	The Charitable Funds Policy.	1	Design	Medium
2	Income/Donations supporting documentation.	2	Operation	Medium
4	Charitable Funds Expenditure.	3	Operation	Medium
6	Fundholder Reports	4	Design	High
7	Charitable Funds Committee Terms of Reference.	5	Operation	Medium

Introduction

1.1 Our audit review of Charitable Funds was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The Powys Teaching Health Board Charitable Fund (the 'Charity') was formally created on the 28th May 2004 by a 'Deed of Arrangement' and replaced the Powys Health Care NHS Trust Charitable Fund, which had been in existence since 26th July 1996, following the transfer of charitable funds from Dyfed Powys Health Authority.

1.3 The Charity has an umbrella Charity registration under which funds are registered together under a single 'main' registration number.

1.4 Charitable funds donated to the charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service.

1.5 The Health Board is the Corporate Trustee of the Charitable Funds and has devolved responsibility for the on-going management of the charity to the Charitable Funds Committee who administer the funds on behalf of the Corporate Trustee.

1.6 For the period 1st April 2021 to 31st March 2022 the charity had received donations of £540k and had expenditure of £217k. As of 31st March 2022 the Charity's Investment portfolio position was £3,548k.

1.7 The Executive Director of Finance and ICT was the lead for this review.

1.8 The associated risks for the audit review were:

- Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.
- Charitable funds income isn't maximised.
- Monitoring, reporting and oversight arrangements may be inadequate.
- Non-compliance with legislation or Charity Commission guidance.

Detailed Audit Findings

Objective 1: Appropriate guidance is in place which adequately covers receipt of income, expenditure, fundraising and investments.

2.1 A policy is in place for Charitable Funds which is readily accessible to all staff via the Health Board's Intranet page for non clinical policies. The Health Board also has a dedicated website for Fundraising where further information is available.

2.2 The policy states that it was last updated in June 2020 with a review due in June 2022. At the time of the audit we were unable to evidence that this review has taken place.

2.3 The guidance is generally detailed and comprehensive although some areas for improvement were identified. (Matter Arising 1)

Conclusion:

2.4 A policy is in place for Charitable Funds which is generally detailed and comprehensive and is readily accessible. We have provided Reasonable Assurance for this objective.

Objective 2: Charitable funds income received is appropriate and accounted for correctly (including gift aid).

Income donations:

2.5 A sample of 24 Charitable Funds income transactions was reviewed to establish if all donations had supporting documentation and that income was allocated to the correct fund.

2.6 For 23 out of 24 transactions, the supporting documentation fully supported the transaction and all monies had been allocated to the correct fund. However, for one transaction, only partial supporting documentation had been provided. (Matter Arising 2)

2.7 All transactions within the sample had been posted correctly to Oracle.

Gift Aid:

2.8 We reviewed the most recent Gift Aid claim. This covered the last three years (2019/20 - 2021-22) and, for a sample of transactions, we confirmed that it was supported by relevant documentation.

2.9 Gift Aid transactions are accrued annually in Oracle for accounts purposes. For the sample of transactions, we confirmed that they had been recorded correctly in Oracle.

2.10 The preceding Gift Aid claim also covered three years (2016/17 - 2018/19). We recommend that Gift Aid claims should be submitted at least annually in line with the Charitable Funds annual accounts. (Matter Arising 3)

Conclusion:

2.11 From the testing undertaken we found that the processes in place for the recording of charitable donations and gift aid are operating effectively. We did identify an issue regarding supporting documentation for one of the income sample tested. We have provided Reasonable Assurance for this objective.

Objective 3: Charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund.

2.12 We undertook testing on a sample of 20 expenditure transactions covering a range of Charitable Funds and spread throughout the first half of 2022/23.

2.13 For each transaction, we reviewed the supporting documentation to determine whether the transaction:

- Was in line with the purpose of the Charitable Fund;
- Had been requested in line with the guidance;

- Had been approved by an authorised signatory;
- Had been approved in line with the financial limit; and
- Had been posted correctly to Oracle.

2.14 The results of our testing found that all expenditure was in line with the purpose of the fund and had been appropriately authorised.

2.15 However, we did identify an issue around the completion of the application form with applicants not identifying the fund number that the expenditure was to be incurred. (Matter Arising 4)

2.16 We also noted that the development of a sign off checklist might be beneficial to concisely summarise when supporting documentation was completed and where it is located, as when we undertook our testing it was not always clear where supporting documentation was filed and so it could not be quickly located. (Matter Arising 5)

Conclusion:

2.17 From the testing undertaken we found that the processes in place for Charitable Funds expenditure are operating effectively, although an issue was identified with one expenditure item. We have provided Reasonable Assurance for this objective.

Objective 4: Funds held in Trust are appropriately monitored, managed and invested.

2.18 Overall financial reports are presented at the quarterly Charitable Funds Committee meetings which provide a breakdown of the closing balances, income & expenditure movements, graphical summaries and a key message summary.

2.19 Similarly, overall investment reports are presented at the quarterly Charitable Funds Committee meetings which provide a valuation summary, gross income and investment yield by category supported by a detailed narrative review.

2.20 Regular monthly Charitable Funds reports have not been issued to each fundholder and then discussed with them. (Matter arising 6)

Conclusion:

2.21 Overall financial and investment reports are presented at the quarterly Charitable Funds Committee meetings which clearly provide detailed information regarding the key messages. However, regular monthly Charitable Funds reports have not been issued to each fundholder and discussed with them. We have provided Reasonable Assurance for this objective.

Objective 5: The role of the Charitable Funds Committee is appropriately defined and provides adequate oversight for Charitable Funds.

2.22 The Charitable Funds Committee has Terms of Reference (dated July 2021) in place which are detailed and comprehensive. The Terms of Reference should be reviewed

annually by the Committee but from our review of the committee of the past year we have been unable to evidence a review of the Terms of Reference. (Matter arising 7)

2.23 The Charitable Funds Committee meets quarterly in accordance with its Terms of Reference. All meetings in the last year have been quorate.

2.24 The Charitable Funds Committee meetings cover all areas expected. These are set out in its Terms of Reference.

2.25 Agendas and papers are prepared in advance of each meeting and minutes are prepared and approved following each meeting.

2.26 The Charitable Funds Committee receives quarterly financial and investment updates and considers and approves applications which exceed delegated approval limits.

Conclusion:

2.27 The Charitable Funds Committee has detailed and comprehensive Terms of Reference in place and quorate meetings are held which cover all areas expected and comply with the requirements of these Terms of Reference. However, we have been unable to evidence that the annual review of the Terms of Reference by the Charitable Funds Committee has taken place. We have provided Reasonable Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Charitable Funds Policy (Design)	**Impact**

A policy is in place for Charitable Funds which is generally detailed and comprehensive. However, some areas for improvement were identified:
• The Charitable Funds Policy was due for review in June 2022 but is yet to be undertaken.
• Supplementary Charitable Funds documents are not reflected or referenced in the policy. These include:
  • PTHB Charity Funding Guidelines 2022.
  • Donations and Gift Guidance for PTHB Staff Dec 2021.
  • Public Fundraising Information Pack.
  • Application process flowchart.
  • Charitable Funds full application form.
  • Local Funds application form.
	Potential risk of Charitable Funds guidance not being followed correctly.

Recommendations		**Priority**
1.1	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed – The policy recommendations have been actioned, reviewed and approved by the Charitable Funds Committee since the fieldwork, in December	January 2023	**Charity Manager**

	2022. The updated policy will be published and disseminated to staff once the formal minute has been confirmed.		

Matter Arising 2: Income Donations supporting documentation (Operation)	**Impact**
We undertook testing on a sample of 24 income transactions to ensure that all donations had appropriate documentation and that the monies received had been allocated to the correct fund. The following was noted: • For 23 of the sample full supporting documentation was present and the monies had been allocated to the correct fund. • For one transaction the amount recorded was the total of a number of cheques received in respect of McMillan nurses. The supporting evidence provided did not match the total recorded on the C&D sheet. Good practice would be to record each donation individually on the C&D sheet.	Monies allocated incorrectly.

Recommendations		**Priority**
2.1	Management should ensure that where multiple donations are received regarding an event, or 'in memory of' , each donation is recorded individually on the C&D sheet.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed an email reminder of this requirement to relevant staff has been sent	Actioned since audit fieldwork	**N/A**

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Matter Arising 3: Gift Aid claims (Operation)			**Impact**
When we reviewed the processes for recording and claiming gift aid, we noted that the most recent Gift Aid claim £3,853.78 covered the last three years (2019/20 - 2021-22). It was also noted that the preceding Gift Aid claim also covered three years (2016/17 - 2018/19).			Gift Aid income is not received on a timely basis.
Recommendations			**Priority**
3.1	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.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed - Gift aid claims will be undertaken on at least an annual basis	**Jun 23**	**Head of Financial Services**

Matter Arising 4: Charitable Funds Expenditure (Operation)	**Impact**
We undertook testing on a sample of 20 charitable funds expenditure transactions to ensure that all expenditure was appropriate and had been authorised. The following was noted: • For all of the sample we found that expenditure was in line with the terms of the fund and had been appropriately authorised. • However, we did observe that applicants are not noting the fund number that the expenditure is to be incurred from when completing the application form.	Potential risk that payment allocated to the wrong Charitable Fund.

Recommendations		**Priority**
4.1	Management should remind Fundholders that the fund number must be stated on 'Request for Approval to commit Charitable Funds Expenditure Form' when submitting claims for consideration and approval.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed an email reminder of this requirement to relevant staff has been sent	Actioned since audit fieldwork	**N/A**

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Matter Arising 5: Expenditure Sign Off Checklist (Design)			**Impact**
When undertaking our testing on charitable funds expenditure, when asking for all relevant supporting documentation it was noted that not all documentation could be easily retrieved as it was filed in various locations. Development of a sign off checklist might be beneficial to concisely summarise when supporting documentation was completed and where it is located.			Potential risk that supporting documentation may be missed or difficult to locate.
Recommendations			**Priority**
5.1	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.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed a template will be developed and retained for approvals and subsequent actions and dates taken on these approvals	**Mar 23**	**Head of Financial Services**

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Matter Arising 6: Fundholder Reports (Design)			**Impact**
The Finance Department are not currently issuing regular monthly Charitable Funds reports to each individual fundholder and then discussing the position of the funds with them.			Potential risk that fundholders are insufficiently familiar with their Charitable Funds and so incorrect decisions are made.
Recommendations			**Priority**
6.1	Regular monthly Charitable Funds reports should be issued to each fundholder and discussed fully with them.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Monthly reports have been issued to each fundholder by the finance department for October and November 22 and will continue to be sent monthly. Long term strategies for significant funds (above £100k in value) are also being developed with each fundholder.	**Actioned since Audit fieldwork**	**N/A**

Matter Arising 7: Charitable Funds Committee Terms of Reference (Operation)			**Impact**
Each Health Board Committee is required to review its Terms of Reference annually. From our review of the Charitable Funds Committee meetings over the last year we have been unable to evidence that the review has taken place.			Potential risk from non compliance with Welsh Government recommended best practice.
Recommendations			**Priority**
7.1	Management should ensure that the Charitable Funds Committee review the Terms of Reference as soon as possible.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Agreed – The Terms of Reference has been updated, reviewed and approved by the Charitable Funds Committee at the December 2022 meeting.	Actioned since Audit fieldwork	**N/A**

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Workforce Futures Strategic Framework

Final Internal Audit Report

January 2023

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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Auditors:	Lucy Jugessur –Internal Audit Manager Ian Virgill – Head of Internal Audit
Executive sign-off:	Deborah Lawson-Wood – Interim Executive Director for Workforce and OD
Distribution:	Mark McIntyre – Deputy Director of Workforce and OD Sarah Powell – Assistant Director of Workforce and OD Louise Richards – Strategic Workforce Lead for Healthcare and Partnership
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 is to provide assurance that the framework has started to embed and is providing clear direction of the future work required to achieve the outcomes intended.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Management need to ensure annual updates are provided on the outcomes or whether more regular evaluations should be undertaken.
- The action plans for the Workforce Futures Framework Programme Board and Workforce Futures Oversight Group could not always be followed from one meeting to the next meeting.

Other recommendations / advisory points are 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	Effective partnership working and governance arrangements in place	Substantial
2	The Framework has set outcomes and these are monitored and action taken where necessary	Reasonable
3	The Workforce Futures Framework Programme Board and Operational Group are set up	Reasonable
4	Dedicated staffing partnership and financial resources in place	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	Evaluation on outcomes	2	Operation	Medium
2	Action plans for the Workforce Futures Framework Programme Board and Workforce Futures Oversight Group	3	Operation	Medium

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1. Introduction

1.1 Our review of Workforce Futures Strategic Framework was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching University Health Board (the 'Health Board').

1.2 The Workforce Futures Strategic Framework was launched in March 2020 and is a key enabler of the Health and Care Strategy for Powys: *A Healthy, Caring Powys.* It was produced to help ensure that the Health Board have a strong, cross sector workforce to enable delivery of the strategy to improve health and wellbeing for the people of Powys.

1.3 The Workforce Futures Strategic Framework was developed by engaging with staff, volunteers, carers and workforce colleagues across partners of the Regional Partnership Board, citizen representatives, and others who contribute to addressing the health and care needs to Powys citizens and communities. A number of themes emerged from engagement and these have been included as five core themes within the Framework:

- Designing, Planning and Attracting the Workforce.
- Leading the Workforce.
- Engagement and Wellbeing.
- Education, Training and Development.
- Partnership and Citizenship.

1.4 Alongside these themes, a further cross cutting theme was identified to utilise Technology and Digital Infrastructure.

1.5 The Lead Executive for this review is the Interim Director of Workforce and Organisational Development.

1.6 The potential risks considered in the review were as follows:

- The goals and objectives of the Framework are not being monitored, reviewed and implemented in line with the agreed milestones.
- Reputational damage as the Framework goals and objectives are not achieved.
- Current RIF funding is tapered and therefore without a sustainable financial model the work programme will reduce and potentially fail to deliver the ambition.

2. Detailed Audit Findings

Objective 1: There are effective partnership working and governance arrangements in place around the Workforce Futures Strategic Framework and regular reporting is taking place at relevant levels within the Health Board.

2.1 There is a Workforce Futures Programme Board in place who are responsible for the strategic decision making and leading the work programme. There is also an Operational Oversight Group who are responsible for working to develop the initiative. The Programme Board and the Operational Oversight Group have representatives from the Health Board, County Council, PAVO - Volunteer sector,

Carer representative and Commissioning representative, so all partners are represented.

2.2 Updates on the Workforce Futures are provided to the Workforce and Culture Committee on a quarterly basis. Any further updates on the Workforce Futures are provided through the Directors report. The Board have received updates on the Workforce Futures via the Committee updates.

2.3 As well as updates being provided to the Workforce and Culture Committee, the same updates were provided to the Executive Committee.

2.4 A highlight report has recently been produced for the Workforce Futures Programme Board and is classified by each theme detailing whether the priority is on or off track. The highlight report will be taken to the Workforce and Culture Committee when requested.

Conclusion:

2.5 Effective partnership and governance arrangements are in place for the Framework. Reporting is taking place within the Health Board via updates provided to the Workforce and Culture Committee. Further updates are provided to the Committee via the Directors report as required. We have provided Substantial Assurance for this objective.

Objective 2: The Framework has set outcomes, and these are being monitored and action taken where necessary to ensure effective delivery.

2.6 There were five key themes included within the Workforce Futures Strategic Framework that was produced in January 2020 and 32 outcomes had been established under them for achievement by 2022.

2.7 A "Review 2019-22 and Future Delivery Plan 2022-25" paper was produced in December 2021 detailing all the themes and outcomes and the activity that had been achieved against each of them. Activity had occurred on all the outcomes but there was work still required to be carried out on some of the outcomes.

2.8 We reviewed two of the themes as follows:

Theme 2: Leading the Workforce

There were eight outcomes within this theme and activity had been undertaken for all of them. However, it was recognised that further work was required on four of the outcomes within 2022.

Theme 4: Education Training and Development

There were four outcomes within this theme. The outcome that related to the Health and Care faculty in Powys had been achieved but the other three outcomes needed further work within 2022.

At the time of the Audit, all the planned outcomes had not been achieved but action had been taken on them. The reasons provided for the delays were due to reliance on other projects and themes within the Framework.

2.9 We were advised that another annual evaluation providing an updated status of the 2022 outcomes will be carried out in January 2023. **(Matter Arising 1)**

2.10 A Workforce Futures Highlight report was produced and taken to the Workforce Futures Framework Programme Board October meeting. The report was classified by each theme detailing the strategic priority and whether it was on or off track. It also included the regional 22/23 objectives, and these were rag rated and it confirmed the progress that had been made against the milestones in quarters 1 and 2.

2.11 There were two Strategic Priorities within the Leading the Workforce theme, and both were on track with four of the objectives classed as green rag rated and three rag rated grey. There were two Strategic Priorities under the Education, Training and Development theme and confirmation that overall, the Strategic Priority was on track.

2.12 There were 14 regional 22/23 objectives and 11 were rag rated green and three rag rated grey highlighting that they have not started. Although the wording of the objectives was different to the wording of the outcomes, these objectives are the actions that need to be undertaken to achieve the overall 32 outcomes detailed within the Framework.

Conclusion:

2.13 The 2022 planned outcomes within the themes have either been completed or further action was required on them to be completed. An annual evaluation is to be undertaken in January 2023 to provide an update on all outcomes. We have provided Reasonable Assurance for this objective.

Objective 3: The Workforce Futures Framework Programme Board and Operational oversight Group are appropriately set up and are operating effectively and have the necessary skills and experience to deliver against the Framework.

2.14 As detailed in objective 1, the Workforce Futures Framework Programme Board and Operational oversight Group have both been set up and both have terms of reference in place.

2.15 The terms of reference (TOR) for the Workforce Futures Programme Board confirms that its purpose is to "deliver the outcomes outlined in the Workforce Strategic Framework, 2020."

2.16 There were minutes and action plans developed for the Workforce Futures Programme Board meetings. We reviewed the action plans, and it was evidenced that the status of all the actions could not be clearly followed from one meeting to the next. **(Matter Arising 2)**

2.17 The TOR confirms that the Board will meet bi-monthly initially with a view to moving quarterly once established. We reviewed the representation for the last three Workforce Futures Programme Board meetings and there was representation from Powys Teaching Health Board, Powys County Council and PAVO. The July meeting was not quorate so it was agreed that no decisions would be made. The

meetings were due to be held bi-monthly, but the April meeting had to be cancelled and the August meeting was cancelled due to a changeover of senior leaders and was non-quorate. **(Matter Arising 3)**

2.18 The TOR for the Programme Board states that the Board will "address agreed Powys Regional Partnership Board (RPB) workforce priorities in a planned and systematic manner, and will report progress on a regular basis... These will be reported at regular intervals by the Chair to the RPB." We evidenced that the Programme Board reported into the RPB on the 19th May 2022 with an update on the five themes including the Health and Care Academy and where investment has been received from. We were advised that there has been no further update on the Workforce Futures to the RPB since that meeting. **(Matter Arising 3)**

2.19 The TOR confirms that the Workforce Oversight Group will meet bi-monthly and they met in March, May, August and October 2022. The TOR states that "meetings will be quorate if there is attendance from 2 key bodies of Local Authority, Powys Teaching Health Board, PAVO, a Carers representative and a Social Care representative present, and must include either the chair or vice chair." We reviewed the attendance of the meetings and there was representation from the 2 key bodies for all meetings as required.

2.20 There were minutes and action plans developed for the Oversight Group meetings. As with the Workforce Futures Programme Board we were unable to evidence that the action status could be clearly followed from one meeting to the next. **(Matter Arising 2)**

2.21 The Oversight Group are not always undertaking the work as effectively as they could be to ensure effective delivery of their role, as detailed within the TOR. **(Matter Arising 4)**

Conclusion:

2.22 Workforce Futures Framework Programme Board and Workforce Futures Oversight Group are in place and are attended by representatives from the partnerships. The action plans for both could not always be followed from one meeting to the following meeting. The Board did not always meet and did not report regularly to the Powys Regional Partnership Board. The work of the Oversight Group also needs to be reviewed. We have provided Reasonable Assurance for this objective.

Objective 4: There is dedicated staffing partnership and financial resources in place within the Health Board to enable the Framework to operate.

2.23 A "Review 2019-22 and Future Delivery Plan 2022-25" paper was produced in December 2021. It included a section on Resources which stated that "the programme of work to date, including infrastructure costs have been resourced by Integrated Care Fund (ICF) funding for 2021/22, with some additional upfront funds made available through other sources including Health Board core funds, charitable funds and Health Board capital to support the development of the Health & Care Academy hub. Grants have also been made available through national streams to support the development of the 5-year strategy for Volunteers and Carers." Included within the paper was a table outlining the financial spend against

the funds allocated for 2021/22. We reviewed the table and £1,250,000 had been spent from the ICF funding and £371,875 had been spent through the other resources. It was detailed that continued financial investment is required for the continued programme of work to build on the foundations laid.

2.24 The paper also included a resource requirement analysis, which was completed for the work planned over the next 3 years (2022-25) to achieve the outcomes stated in the Workforce Futures Strategic framework. There was a draft Workforce Futures structure detailing the core team required to support the work going forward. We were advised that the structure is in place now and during quarter 4 of 2022/23 an evaluation of the impact of the roles within the structures will be undertaken to assess whether these roles will be required and/ or something different for future years. The evaluation is being undertaken as they will need to reapply for the funding for these roles.

2.25 It was stated within the paper that there would be an estimated investment from the other resources for 2022/23 of £385,671 and an ICF funding request for £327,919. We were advised that the investment has been received and it predominantly funds the structure for 2022/23.

2.26 The report further stated that the programme team will seek funding from national sources to ensure the work over the next 3 years and some funding has been received from HEIW, on a year-by-year basis, but we were further advised that the continued investment of this relies upon a sound evaluation and investment streams.

Conclusion:

2.27 There is a staffing structure in place for the Workforce Futures Strategic Framework which if funded through the ICF and other sources. The structure in place will be reviewed for 2023/24 to confirm whether it is appropriate as part of the reapplication for funding. We have provided Substantial Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Evaluation on outcomes (Operation)			**Impact**
A "Review 2019-22 and Future Delivery Plan 2022-25" paper was produced in December 2021 detailing all the themes and outcomes and the activity that had been achieved against each of them. We were advised by the Strategic Lead for Health, Care and Partnership that an evaluation would be undertaken in January 2023 to evidence what had been delivered and achieved within 2022. The reporting on the activity highlights all outcomes that have been achieved and any that require further work.			Potential risk of: • The goals and objectives of the Framework are not being monitored, reviewed and implemented in line with the agreed milestones.
Recommendations			**Priority**
1.1	Management should ensure that the Annual evaluation on the 2022 outcomes is reported in January 2023 as planned, to confirm if all the outcomes had been achieved or if there was any further action required on them. Consideration should be taken as to whether more regular reporting than annually should be undertaken on the themes and outcomes to ensure that if there is any slippage this can be identified earlier.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The annual evaluation on 2022 outcomes is planned to be added to the agenda for the next Programme Board which is scheduled for the 6th February '23'. NB Programme Board for January '23' was rescheduled to 6th February due to winter pressures.	6th February 2023	Strategic Workforce Lead for Health, Care & Partnership

Matter Arising 2: Action plans for the Workforce Futures Programme Board and Oversight Group (Operation)	**Impact**
There is a Workforce Futures Programme Board and a Workforce Futures Oversight Group in place. Both have regular meetings as detailed within the terms of reference and actions are produced from these meetings. However, we identified a number of issues with the action plans for both. **The Workforce Futures Programme Board** • Action dates were being revised from one meeting to the next but stating the action was on track even though the action date had been put back. • Actions were recorded on the action plan on one meeting as 'Action due' but were not then recorded on the following action plan for the next meeting so we were unable to confirm whether the action had been completed. **The Workforce Futures Oversight Group** • We reviewed the action plans and there were two actions recorded on the action plan at the meeting at the March Group as 'On Track' but they were no longer included on the May action plan, so we were unable to confirm whether the action had been completed. • Three actions on the May action plan were no longer on the August action plan, but there was no evidence to suggest they had been actioned. • There were three new actions on the August action plan but there was no detail as to where these originated from.	Potential risk of: • The goals and objectives of the Framework are not being monitored, reviewed and implemented in line with the agreed milestones.
Recommendations	**Priority**
2.1 There should be narrative on all actions within the minutes of both the Board and Group to confirm whether they have been completed, reasons for revised dates and information to where the new actions have originated from.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	Narrative on all actions within the minutes of both the WFF programme Board and Oversight groups will be included at all meetings minutes from this point onwards (January '23). This will include reasons for revised dates and information to where any new actions have originated from.	February '23	Anna Lote-Jones - Workforce Futures Business Manager

Matter Arising 3: Workforce Futures Programme Board meetings and reporting (Operation)	**Impact**
The Workforce Futures Programme Board has not been able to meet bi-monthly during 2022, in line with the terms of reference, as the April meeting was cancelled and the August meeting was cancelled due to a changeover of senior leaders and was non-quorate. The terms of reference for the Workforce Futures Programme Board states that the Board will report progress on a regular basis to the Powys Regional Partnership Board but had only reported to them on the 19th May 2022.	Potential risk of: • The goals and objectives of the Framework are not being monitored, reviewed and implemented in line with the agreed milestones.

Recommendations		**Priority**
3.1	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.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	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.	End March '23	Anna Lote-Jones - Workforce Futures Business Manager Strategic Workforce Lead for Health, Care & Partnership

Matter Arising 4: Role of Workforce Futures Oversight Group (Operation)			**Impact**
The terms of reference of the Workforce Oversight Group (WFOG) states that they are to "oversee the work required to be undertaken, as directed by the Strategic Workforce Futures Programme Board". They are to focus on workforce delivering services through the five key themes of the Workforce Futures Strategic Framework. However, it was not always evident that they were undertaking the work sufficiently as they should be.			Potential risk of: • Reputational damage as the Framework goals and objectives are not achieved.
Recommendations			**Priority**
4.1	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.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Actions allocated to the oversight group from WFF Board should be tracked and reported as part of the WFF highlight report at each meeting.	End of July '23	Strategic Workforce Lead for Health, Care & Partnership

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Welsh Language Standards
Final Internal Audit Report

December 2022

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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Auditors:	Sharon Edwards, Principal Auditor Jayne Gibbon, Audit Manager
Executive sign-off:	Claire Madsen, Director of Therapies & Health Science
Distribution:	Adam Pearce, Service Improvement Manager Welsh Language & Equalities Sian Jones, Welsh Language & Equality Services Officer
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 review was to assess the processes in place within the Health Board to ensure compliance with the requirements of the Welsh Language Standards Act.

Overview

We have issued limited assurance on this area.

The matters requiring management attention include:

- Undertake a full review of the current action plans to ensure that each service area is aware of the Welsh Language requirements that are applicable to them, plans are up to date and lead details correct.
- Welsh Language Team need to meet with Leads for individual action plans to note progress and discuss issues.
- Production of a policy for Welsh Language.
- Establish an appropriate structure for active monitoring and reporting of the Welsh Language Standards compliance.
- Review all signage including temporary signs across the Health Board.
- Ensure that Welsh Language guidance is uploaded to new Sharepoint Intranet as soon as possible.
- Management to review current processes in place for reviewing any risks associated with Welsh Language Standards to ensure risks are recorded on departmental risk registers where applicable.

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Creating and Implementing Action Plans	Limited
2	Monitoring and reporting to arrangements	Limited
3	Testing on compliance of Signage & Recruitment standards	Reasonable
4	Staff awareness	Reasonable
5	Identification and management of risks relating to the standards.	Limited

[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	Service Group Action Plans	1	Design	High
2	Monitoring of compliance with the action plans	1	Design	High
3	Welsh Language Policy	1	Design	High
4	Monitoring and Reporting on compliance	2	Design	High
5	Welsh Language Annual Report	2	Design	Medium
6	Estates – Signage	3	Operation	Medium
7	Staff Awareness	4	Design	Medium
8	Level of Risk	5	Operation	High

1. Introduction

1.1 The review of Welsh Language Standards was completed in line with the Powys Teaching Health Board's (the 'health board') 2022/23 Internal Audit Plan.

1.2 In March 2018, Assembly Members voted in favour of the Welsh Standards [No 7.] Regulations 2018. The two key principles that underpin the regulations are:

- In Wales, the Welsh Language should be treated no less favourably that the English Language; and
- persons in Wales should be able to live their lives through the medium of Welsh language if they chose to do so.

1.3 The financial penalty for non-compliance with the Standards could be a civil penalty of up to £5,000 per breach.

1.4 In July 2018, the Welsh Language Commissioner issued a draft compliance notice to all Welsh health organisations. After a twelve-week consultation period, responses on the reasonableness and proportionality of implementing each standard were submitted to the Commissioner by all Welsh health organisations.

1.5 The Health Board's Compliance Notice was formally issued on 30 November 2018. In most instances the standards were imposed by 2019, with a minority by 2020, which related to the Health Board's website.

1.6 The Health Board's progress in taking forward the Standards has been impacted by COVID-19.

1.7 The Executive Director of Therapies and Health Science is the lead for this review

1.8 The potential risks considered in the review were as follows:

- Financial penalties and reputational damage if the Health Board is unable to comply with the Standards, within the timescales agreed with the Welsh Language Commissioner.

- Patients that request communication in the Welsh language are treated unfairly.

2. Detailed Audit Findings

Objective 1: The process for creating and maintaining implementation action plans in response to Compliance Notices issued by the Welsh Language Commissioner

2.1 The Welsh Language Commissioner's Compliance Notice is held on the Health Board's website, within the 'Welsh Language in Healthcare' pages.

2.2 On receipt of the compliance notice the previous Welsh Language Officer met with Service Leads to determine which standards related to them in order to compile action plans across the Health Board.

2.3 The action plans have not been reviewed by the Welsh Language Team since they were originally drawn up following receipt of the compliance notice. Each action plan had been allocated to a Service Lead / responsible officers and they were requested to implement the standards and identify what actions were required.

2.4 From our fieldwork we noted that some of the identified Service Leads / Responsible Officers for the action plans are no longer in post, but no notification had been sent to the Welsh Language team. Our review of the action plans provided by the Welsh Language Team noted that there is very little narrative or evidence within the action plans to detail the status of the implementation of the standards. **(Matter arising 1)**

2.5 The action plans were reviewed to establish whether all of the standards from the Compliance Notice had been included. We noted that three of the standards were not included on any action plans. **(Matter Arising 1)**

2.6 A master copy "Standard Monitoring Document" has been produced by the Welsh Language team to show the compliance with the standards, but this does not reflect the same information that is recorded in the individual action plans. Seventeen standards have been marked as "red" but do not have details within the narrative to outline why they are non-compliant or what actions need to be taken. **(Matter arising 2**)

2.7 Welsh Language Policy Standard 79 requires the Health Board to develop a Policy on using Welsh internally. At the time of the audit there was no policy in place, but we do acknowledge that the Health Board is in the process of completing one. **(Matter Arising 3)**

Conclusion:

2.8 Overall, the Welsh Language team need to develop an effective approach to reviewing the current action plans that are in place by making sure that the standards are appropriate for each Service Area, they have up to date responsible officers, and that the information within the action plans are up to date and accurate as this will help to aid the compliance across the Health Board. We have provided Limited Assurance against this objective.

Objective 2: The arrangements for monitoring and reporting on delivery of the action plans and compliance with the standards

2.9 There is currently no effective working group in place where the compliance with Welsh Language Standards is discussed in depth or the individual Services action plans are reviewed in detail. We do note that updates are provided at an Executive level but these are more on an exception basis. **(Matter Arising 4)**

2.10 There are Welsh Language Service Leads meetings which are supposed to be held bi-annually but these are not well attended. We also note that individual action plans are not reviewed at the meetings. **(Matter Arising 4)**

2.11 The Welsh Language Annual Report for 2021/22 was presented and discussed at the Workforce & Culture Committee in May 22 and it was then presented to the Board in July 22 for approval. However, the results of our testing, as detailed within this report, has identified areas for potential development prior to the production of the 2022/23 Report. **(Matter Arising 5)**

Conclusion:

2.12 The Health Board does not currently have an appropriate group in place where the standards can be discussed, and individual plans scrutinised. The absence of a group means that it is difficult to identify issues that need to be escalated or information that should be cascaded down to the Services. We have provided Limited Assurance for this objective.

Objective 3: The extent to which departments within the Health Board are achieving compliance with a sample of standards: Signage and Recruitment

2.13 Standards that relate to signage are on the Estates action plan. However, all departments are responsible for ensuring that any temporary signage is bilingual, but they may be unaware of this requirement. This was reflected when we visited three sites across Powys as there were many temporary signs that weren't bilingual. **(Matter Arising 6)**

2.14 Standards that relate to recruitment are on the Workforce and Organisation Development Action Plan.

2.15 A Welsh language Skills Assessment Tool has been introduced to assess the level of Welsh required for a post and establish if it is desirable or essential. This tool has been praised by the Welsh Language Commissioner.

2.16 There are appropriate processes in place within the Workforce department to ensure that all vacancies meet the requirements of the Welsh Language Standards before the advert is placed.

Conclusion:

2.17 It is evident that the Health Board is not complying with the Welsh Language Standards in relation to temporary signage. Processes are however in place to ensure compliance with the recruitment standards. We have provided Reasonable Assurance for this objective.

Objective 4: How staff are made aware of the requirements of the Standards

2.18 We were provided with sight of the information that is going to be added to the new Share Point Intranet site and it covers learning for staff, translation services and who to contact, 'More than Words' and 'Active Offer' along with guidance and communication information.

2.19 However, the intranet pages are not currently available as the Health Board is still currently populating the new intranet site on Sharepoint. **(Matter Arising 7)**

2.20 The Health Board's new internal translation service has delivered a considerable increase in translation requests and has been well received by staff from the Estates and Safeguarding Departments who were approached during the audit review.

2.21 Information relating to the Welsh Language is made available to staff via the "Announcements" which are sent out on a regular basis to all staff across the Health Board.

2.22 Apps and social media can be introduced by any department across the Health Board, but the standards relating to these are not on their action plans, so staff may be unaware of the need for information to be provided bilingually **(Matter Arising 7)**

Conclusion:

2.23 The Share point pages, and intranet pages are not currently available so staff may be unaware of where to obtain advice about any Welsh Language query. We have provided Reasonable Assurance for this objective.

Objective 5: Risks relating to the Standards are appropriately assessed, recorded and monitored on Corporate and Departmental risk registers.

2.24 We note that a risk regarding compliance with the Welsh Language Standards is recorded on the Health Board's Risk Register (reference CRR 012). Responsibility for monitoring the risk is delegated to the Workforce and Culture Committee.

2.25 An update on the Corporate Risk CRR 012 report was submitted to the May 2022 meeting of the Workforce & Culture Committee. However, elements of the risk assessment relating to current "Controls" may not be accurately stated as they do not reflect the findings from our audit fieldwork. We were also unable to identify if Welsh Language risks relating to individual service areas have been added to their respective risk registers. **(Matter Arising 8)**

Conclusion:

2.26 The risk assessment that is in place for the Welsh Language Standards should be reviewed by management to ensure that the current stated controls and actions being taken are accurate. Furthermore, consideration should be given to cascading the risk relating to the Welsh Language Standards down to Services departmental registers. We have provided Limited Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Services Action Plans (Design)	Impact
Action plans were originally produced in 2019 by the previous Welsh Language Officer in collaboration with the Service Leads at the time. They have not been reviewed since they were first introduced. Twenty action plans had been sent out to each service area and they were expected to implement the standards that had been assigned to them without much interaction from the Welsh Language Team. As a consequence of the lack of engagement, there is very little information provided as evidence within the narrative section of the action plans to show the status or progress that has been made. e.g. Therapies, Communication engagement, Quality & Safety. The individual action plans identify the Service Lead /Responsible Officer within the Service Group. After reviewing all of the action plans, it was evident that these are not accurate or up to date as several Service Leads / Responsible Officers who had been identified have either left the organisation or changed roles. The Learning Disabilities and Mental Health action plan has been split into five sub-categories which makes it difficult to establish the level of compliance across the Service as a whole. The responsible officer has not been identified for these action plans. The action plan for Managed Practice did not have any information within evidence, rag rating, possible actions or person responsible despite having 59 standards assigned to them. We have compared the standards assigned to each action plan to the compliance notice and could not see evidence of standards 75,76 or 77 on any of the service group action plans. The Welsh Language Team have an overall master copy of the standards which implies these are 95% compliant. Paterson,Liz 01/02/2023 09:10:51	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
1.1a	The Welsh Language Department should undertake a review of all existing action plans as soon as possible to determine if the standards originally assigned to all the services are still appropriate and applicable. This will also ensure that all the standards from the compliance notice have been assigned to an appropriate service area. This will also provide an opportunity to ensure that an up-to-date position is recorded for each of the standards within each action plan, along with identifying the appropriate service leads /responsible officers for each area. The Welsh Language team should encourage the service leads to devolve and further cascade the action plans to aid the implementation of the standards within their area.	**High**
1.1b	The responsible officer / service lead should be reminded about the requirement to complete all the columns identified within the action plan which includes evidence, possible action required to meet the standard, and ensure there is an up to date "target date". The Welsh Language team should also reiterate to the Service Lead for the action plan the need to provide regular updates on the status of individual action plans to the Welsh Language Team, as this could help identify areas of non-compliance. Areas of non-compliance and issues will be escalated to the Executive Director of DoTHs as Exec lead for Welsh Language and this will be raised with individual Directors and/or Exec Committee.	**High**

Agreed Management Action		Target Date	Responsible Officer
1.1a	Welsh language team to review existing action plans to ensure they reflect the standards applicable to each team / department. Identify any outstanding issues.	December 2022	Welsh Language Team
	Welsh Language team to contact each service area to ask for a contact who would have responsibility for the Welsh Language.	December 2022	Welsh Language Team Directors, Deputy Directors and Assistant Directors (ADs)
	Contact list to be verified with Hayley Thomas.	End 2022	Exec Dir of Primary Com & MH

	Meetings set up with each new contact to look at establishing new work plans: Contact made with each area. Meetings to be arranged. New action plans in place and quarterly catch-up meetings established between Welsh Language team and service areas.	 During Q1 22/23 March – June 2023 April – July 2023 (following meetings)	 Welsh Language Team Welsh Language Team Welsh Language Service Leads Welsh Language Team Welsh Language Service Leads
1.1b	New action plans in place and quarterly catch up meetings established between Welsh Language team and service areas. Welsh language team to develop & share guidance on how to complete the action plan. Service contacts to update work plans prior to quarterly meetings so they can be discussed.	April – July 2023 By February 2023 July 2023 & Quarterly thereafter	Welsh Language team Senior Managers, AD's and DD's Welsh Language Team Welsh Language Service Leads

Matter Arising 2: Monitoring of compliance with the Action Plans (Design)	Impact
As part of our audit fieldwork, we compared the Standards Monitoring Document that the Welsh Language Department use to report compliance to copies of the services individual action plans that we were supplied with. There are a number of standards that have been identified as green and compliant on the individual service action plans despite being identified as red (indicating 0% compliance) on the Standards Monitoring Document which has been created and held by the Welsh Language Team. There are 125 standards within Powys Teaching health Board Welsh Language Compliance Notice. From reviewing the Standards Monitoring Document, it was established that: • 17 have been marked as "Red"-noncompliant. Of these: Standard 10 which falls within the telephony category has been identified as 10% compliant and although there is narrative within the "Actions Required" column, this needs to be updated to reflect the status to show if the action has been progressed. The 16 remaining standards do not have anything noted within "evidence" / "action required" which should be addressed. If the standards are not applicable to the organisation, it should be confirmed within these columns. It is noted that the Standards Monitoring Document currently reflects the Welsh Language Department's assessment of compliance of the standards with no reference to what is recorded/reflected in individual plans.	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
2.1	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	**High**

	inform the overall compliance position noted in the Standards Monitoring Document maintained by the Welsh Language Department.		
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Senior Managers to ensure Welsh is a recurring agenda item in their regular service meetings.	March 2023	Senior Managers, Ads & DDs
	Service managers to ensure good attendance at quarterly Welsh Language service leads meetings quarterly.	July 2023 & Quarterly thereafter	Service Managers and Welsh Language Service Leads
	Escalate attendance issues or other areas of concern to senior managers, ADs & DDs.	July 2023 & Quarterly thereafter	Welsh Language Team
	Welsh Language team to update the Standards Monitoring Document quarterly following meetings with service areas.	Quarterly	Welsh Language Team

Matter Arising 3: Welsh Language Policy (Design)	Impact
Standard 79 relates to the existence of a Welsh Language Policy for the purpose of promoting and facilitating the use of the language and this must be published on the intranet. The Health Board does not currently have a policy in place, but the Welsh Language Officers are working on developing this and providing additional internal guidance for managers and staff for using the Welsh Language within the workplace. The policy / guidance has yet to be finalised and the Welsh Language section on SharePoint is currently being populated. Once the policy / guidance meets the requirements of the standards, it will be available for staff to access on SharePoint.	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
3.1	Management to ensure that the Welsh Language Policy along with any staff guidance is up to date, accurate and published as soon as possible on SharePoint for point of reference for all staff. The existing Health Board response to this standard has taken the form of a mangers' guidance document, however the Audit has called for a formal policy; the Welsh Language Team will develop this using models from other Welsh health boards.	**High**

Agreed Management Action		Target Date	Responsible Officer
3.1	The Welsh Language Team will develop a formal Welsh language policy summarising the Health Board's position.	By end January 2023 (completed draft) Approval during Q1 2023	Welsh Language Team

Patterson, Liz
01/02/2023 09:10:51

Matter Arising 4: Monitoring and Reporting on Compliance (Design)	Impact
The Welsh Language Standards are on the Workforce and Culture Committee Workplan and progress reporting on the Standards is also made to the Executive Committee on an exception basis. However, there is currently no effective group in place where information relating to the Welsh Language Standards is discussed in depth, or where decisions are made relating to what information should be escalated or cascaded to the relevant people. Although there is a Welsh Language Service Leads meeting, we only saw evidence of two meetings during 21/22. These were not well attended, and it was also acknowledged by the Welsh Language team that there is very little interaction from the Service Leads for Welsh Language and individual action plans were not scrutinised. We also note that no individual meetings take place between each Service lead and the Welsh Language Department to review progress of the action plans and note any issues impacting on compliance.	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
4.1	Management should consider implementing a new process whereby appropriate discussions and scrutinisation of the action plans can be undertaken across the Health Board and includes providing regular updates on the compliance with the standards to an appropriate Executive forum. Consideration should be given to re-establishing the Welsh Language Service leads group which has defined reporting lines, and an appropriate membership and a Terms of Reference in place. Establishing this process could help to identify areas of concern / weakness which may need to be escalated whilst also identifying good practice which could be used to cascade to other Service Leads.	**High**

Agreed Management Action		Target Date	Responsible Officer
4.1	Update Welsh Language Service Leads Group Terms of Reference drafted ready for exec. Consideration. Terms of reference to include clear lines of accountability. ToR to be approved by Execs. Welsh Language service leads group to feed into regular appropriate Executive Forum in the Health board to ensure issues and good practice are fed back to Execs – Workforce and Cultures committee. During 2023, the Welsh team or designated deputies will carry out in-person on-site audits of all main PTHB sites to establish whether compliance on-sites has improved.	End January 2023 During Q1 2023 Implemented into draft Terms of Reference by end December 2022 All main hospital sites visited by end Q3 2023	Welsh Language Team and Directors. Welsh Language Service Leads and Welsh Language Team

Matter Arising 5: Welsh Language Annual Report (Design)	**Impact**
The Welsh Language Annual Report for 2021/22 was initially presented for review and discussion at the Workforce & Culture Committee in May 2022 before being presented to the Health Board meeting that took place in July 2022 for approval and subsequent publication. We reviewed the contents of the report and note the following issues: • It was highlighted within the Report that *"Welsh language service leads meetings were postponed during the pandemic, but they resumed in Spring 2022 in order to review and monitor the implementation of their individual WL action plans. The meetings provide an opportunity for service leads to raise issues, and for updates to be shared as well as discussion on the implications of proposed changes to policy or processes, or of development such as complaints or correspondence form the Welsh Language Commissioner."* The Welsh Language Service leads meetings may provide an opportunity to discuss the standards and raise awareness to issues but these are not being utilised effectively. Whilst we were provided with minutes from the August 22 and March 21 meetings to show what was discussed, it was evident that these meetings were not well attended by the service leads / responsible officer, each individual plan was not reviewed and there was very little interaction from those in attendance. • The Annual Report also relates to the Written Correspondence (Standards 1-7) which states that when the Welsh Language team are contacted by a department, they can help the department to provide communication in Welsh. However, standards 1-7 are not on all service groups action plans which could mean that people are not aware of the Welsh Language requirement. Patterson,Liz 01/02/2023 09:10:51	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
5.1	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5.1	Updates for the Welsh Language annual report and items to be included discussed regularly with the service leads Welsh Language contacts in quarterly meetings.	Quarterly Meetings	Welsh Language Team and Welsh Language Service Leads
	Information collated for the annual report by the Welsh Language team and checked with services prior to presenting to Execs.	March 2023	Executive Directors and Welsh Language Team

Matter Arising 6: Estates Department - Signage (Design)	Impact
The Estates Department Action Plan was reviewed to identify their status with the implementation of the standards. The standards within the Estates action plan have been identified as green. It was decided that where changes have come into force, they should conform with the requirements of the standards i.e. when you erect a new sign or renew a sign or publish or display a notice. It is a requirement of the standards that all signs be bilingual, however the Estates department confirmed that they are not aware of the compliance level with this requirement across the various sites. Visits were carried out across three sites, one in South, Mid and North Powys. Testing showed that although the overall main signage is bilingual, there are various temporary signs in place across all 3 sites which are not bilingual. Signs such as: • Toilets • Waiting area • Please ring for attention • In the interests of hygiene .... • Important notice - Keep clear at all times While visiting the various sites, it was highlighted by a member of staff that they use "Google Translate" to translate the temporary signs into Welsh. However, an employee had been alerted to the fact that the translation was not correct. We did highlight that there is a Welsh Language Team, and translation service that could offer advice, but the member of staff didn't seem aware of this. Standard 49 states that the Welsh language on text or signs is accurate in terms of meaning and expression.	Potential risk of: Patients that request communication in the Welsh language are treated unfairly

Recommendations		Priority
6.1	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
6.1	Signage guidance and Library of temporary signage up on Welsh Language Sharepoint pages.	By March 2023	Welsh Language Team
	Welsh Language team to join the Estates away day in October 2022 to discuss sharing Resources and linking on sharepoint.	November 2022	Welsh Language Team
	Test & Learn of audit of signage to be undertaken by the Therapies Department.	During Q1 2023	Welsh Language Team Welsh Language Team for Therapies
	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).	Spring 2023	Welsh Language Service Leads Support from Welsh Language Team
	Good practice shared by the Welsh language team across other departments.	Spring / Summer 2023	Welsh Language Team
	Welsh Language team to check areas and wards on their roadshows during.	Spring 2023	Welsh Language Team

Matter Arising 7: Staff Awareness (Design)	Impact
The Health Board has moved the hosting arrangements for its Intranet pages to Sharepoint. At the time of the audit any information regarding the Welsh Language had yet to be populated on the new Intranet pages. Staff within the Health Board currently don't have access to advice pages, may not be aware of services that are available to help promote and encourage the use of Welsh, are not able to access bilingual aids, or easily establish where staff can get access to training or Welsh Language lessons. We also note that apps and social media can be introduced by any department across the Health Board without anyone's knowledge, so the Welsh Language Team may need to incorporate information regarding this on the Sharepoint pages so that all staff are aware of the need for information to be provided bilingually as stated in Standards 44 & 45	Potential risk of: Patients that request communication in the Welsh language are treated unfairly

Recommendations		Priority
7.1	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
7.1	Welsh Language sharepoint pages are live and will be regularly updated. Sharepoint pages have been 'launched' on our weekly newsletter Announcements.	September 2022 October 2022	Welsh Language Team Welsh Language Team

	Service managers to highlight Welsh Language pages to teams via all channels	November 2022 to January 2023	Service Managers

Matter Arising 8: Risk Registers (Operational)	Impact
The risk regarding Welsh Language Compliance on the Corporate Risk Register is assigned to the Workforce & Culture Committee for monitoring. We note that an update on the risk was presented to the Workforce & Culture Committee meeting that took place in May 2022. It is reported that for the areas of Clinical, Financial, Corporate and Operational, there is no risk whereas the Reputational risk is identified as low. However, the following information was also reported within the section of "Controls" and "what are we currently doing about the risk": • Welsh Language Steering Group continues to monitor progress against the Standards and is sharing and encouraging best practice • Departmental Action Plans updated – compliance self-assessment completed and returned to WL Commissioner. Compliance levels have increased again during 2021-2022. End of year monitoring meetings held with WL Service Leads. • Continue to monitor compliance levels within each service area and work with Service Leads to address any gaps in compliance However, we were unable to identify the existence of a WL Steering Group, the action plans that were provided for the review showed that all action plans are not up to date and we were advised that meetings with individual service leads to identify areas of concern are only conducted if the Service Lead specifically requests a meeting with the Welsh Language Team. We were not provided with any other minutes of meetings where risks relating to the Welsh Language Standards is discussed. Whilst the Welsh Language Standards is on the overall risk register for the Health Board, we have not been able to ascertain if risks relating to individual service areas have been added to their respective risk registers.	Potential risk of: Financial penalties and reputational damage if the Health Board is unable to comply with the regulations, within the timescales agreed with the Welsh Language Commissioner.

Recommendations		Priority
8.1	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.	**High**

Agreed Management Action		Target Date	Responsible Officer
8.1	Welsh Language discussed internally with DoTHS.	December 2022	Executive Director of Therapies and Healthcare Science
	Reviewed Quarterly.	Ongoing	Welsh Language Team
	Welsh Language Team to meet with Senior Managers to discuss including Welsh Language Standards on departmental risk registers.	March – July 2023	Welsh Language Team and Senior Managers

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.
	**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.

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*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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

Date issued: January 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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Contents

Audit, Risk & Assurance Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Charitable Funds Account	Audit work is now complete, with our closing 'Audit of Accounts Report presented to the Charitable Funds Committee on 16 January. It will be presented further to the Board (as Corporate Trustee) on 25 January, before certification by the AGW on 30 January.
Audit of the 2022-23 Accountability Report and Financial Statements	Audit planning due to start in early 2023 – exact timetable to be discussed with management in due course.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work presented to the Audit Committee (**Exhibit 2**); and
- work that is currently underway (**Exhibit 3**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Review of the Renewal Programme	January 2023

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take 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 will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	National report and local supplementary report due for publication on 23 February March 2023
Review of Unscheduled Care Executive Lead – 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	Blog and data tool published in April 2022 Project brief issued in August 2022. Fieldwork underway May 2023

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	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.	
Structured Assessment Executive Lead - Interim 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: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).	Draft report in clearance March 2023
Primary Care Services - Follow-up Review Executive Lead – 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
Workforce Planning	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the	Project brief issued in November 2022.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	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.	September 2023

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. Details of future events are available on the GPX Website.

NHS-related national studies and related products

5 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

6 **Exhibit 4** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
A Picture of Flood Risk Management	December 2022
'A missed opportunity' – Social Enterprises	December 2022
Time for change – Poverty in Wales	November 2022
Poverty in Wales data tool	November 2022

7 The Auditor General has also recently published his fee scheme for 2023-24.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Review of the Strategic Renewal Portfolio – Powys Teaching Health Board

Audit year: 2021

Date issued: January 2023

Document reference: 3320A2022

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

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

This document is also available in Welsh.

Contents

Summary report

Introduction

1 The last two years have been incredibly difficult for health bodies and the huge task of recovering from the COVID-19 pandemic is underway. For Powys Teaching Health Board (the Health Board), the future direction is not just about recovering to pre-pandemic ways of working, but about building on those recovery processes and simultaneously delivering transformation in the areas of work which matter most to the Powys population. In Powys, this transformation agenda is known as 'renewal.'

2 Recovery and renewal are both parts of the Health Board's vision to improve processes, patient experience and cost. A portfolio was developed to manage the priorities going forward, and in June 2021, the Board agreed six renewal priorities. At the time, the Health Board was in an annual planning cycle as longer-term planning had been suspended due to the pandemic. These priorities formed part of its Annual Plan 2021-22 and approved by the Board on 29 June 2021.

3 The renewal priorities were based on the Health Board's internal appraisal of the impacts of the pandemic and priority needs of the Powys population. They build on the principles of 'A Healthy Caring Powys' and the Health Board's plan to ensure a focus on those things that matter most to the well-being of the population of Powys and those things which will work best to address the critical challenges ahead.

4 The six renewal priority areas identified were:

- Frailty & Community Model;
- Long-term Conditions and Well-being;
- Diagnostics, Ambulatory and Planned Care;
- Advice, Support and Prehabilitation;
- Children and Young People; and
- Tackling the Big Four (Cancer, Breathe Well, Circulatory, Mental Health).

5 However, in September 2021, the long-term conditions priority was removed from the portfolio. There had been several meetings to define the long-term conditions scope but overlaps with other areas risked duplication.

6 Our work looked at how the Health Board is using its resources to recover and transform following the COVID-19 pandemic. We reviewed how the priorities had been set, and whether the delivery and monitoring arrangements established to manage the renewal portfolio are effective.

7 The fieldwork for our review took place between November 2021 and March 2022. During this time, the Health Board was delivering a significant programme of mass vaccination for Powys residents, as well as managing the impact of the omicron variant. As a result, the progress of the renewal portfolio work was interrupted, and staff resources diverted to focus on the Health Board's COVID-19 response. We have taken this into account within the review.

Key messages

8 Overall, **we found that, the Strategic Renewal Portfolio priorities were developed effectively and align with longer-term ambitions. However, the purpose and progress of the portfolio should be more clearly articulated, and the governance arrangements are potentially disproportionately large to the scale of work being delivered.**

9 The strategic renewal priorities were developed effectively and align to the Health Boards ambitions; however, the purpose of the portfolio needs to be clarified to allow for sufficient scrutiny and challenge.

10 Robust governance arrangements are in place for the renewal priorities; however, these may be disproportionate to the scale of work being delivered and there is a risk that the agile nature of the renewal portfolio means core aims of the project become lost.

11 Key points of progress and outcome measures are regularly reported to relevant committees, however, there is scope for the progress to be less narrative and show clearer links to the Health Boards strategic aims.

Recommendations

12 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's organisational response to these recommendations will be summarised in Appendix 1 once considered by the relevant committee.

Exhibit 1: Recommendations

Recommendations
Independent member oversight **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.
Chairing **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

Recommendations

challenge senior executives more effectively and independently, we recommend that the Chief Executive does not act as Chair for one, or both groups.

Governance Structures

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.

Scope Creep

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.

Delivery monitoring

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.

The strategic renewal portfolio priorities were developed effectively, however there is scope to refresh independent member awareness, and refine outcome measures

13 The strategic renewal portfolio priority areas were selected following internal reviews to assess the impacts of COVID-19 on the population of the Health Board. This work commissioned by the Health Board in March 2021 was used to identify harms from COVID-19, as well as identifying areas that had worked well during the pandemic with a view to introducing those revised ways of working. Following this the Health Board developed the six strategic renewal priorities.

14 The strategic renewal portfolio priorities are ambitious and future focused. They are clearly aligned to the Health Board's ten-year vision for health and care in Powys. This vision is set out in the Health and Care strategy published in March 2017, in partnership with the local authority.

15 Value based healthcare is a key feature of the renewal portfolio, which has progressed positively and is embedded throughout the priorities. A dedicated programme for this was established in September 2021, led jointly by the Medical Director and Director of Finance and ICT. Recruitment of a Service Transformation Manager, an analyst and costing accountant has also been undertaken. In June 2022, the Health Board confirmed that work was underway analysing low value interventions, and developing patient reported outcome and experience measures. However, there are recruitment challenges in some areas such as pharmacy which are affecting the programmes capacity.

16 Running alongside the priorities identified within the renewal portfolio is the Health Boards approach to recovery from COVID-19. The Health Board intends to deliver and monitor recovery of its services alongside its focus on renewal as twin tracks. This means simultaneously planning, resourcing, and delivering both aspects concurrently.

17 The day-to-day work of the Health Board, the recovery from COVID-19 and the introduction of the renewal portfolio makes for complex and multi layered delivery. Whilst the staff who are included in the design and delivery of these projects will be clear on the interdependencies and purpose of the work, it can become confusing and difficult to monitor impact for those who are not directly involved.

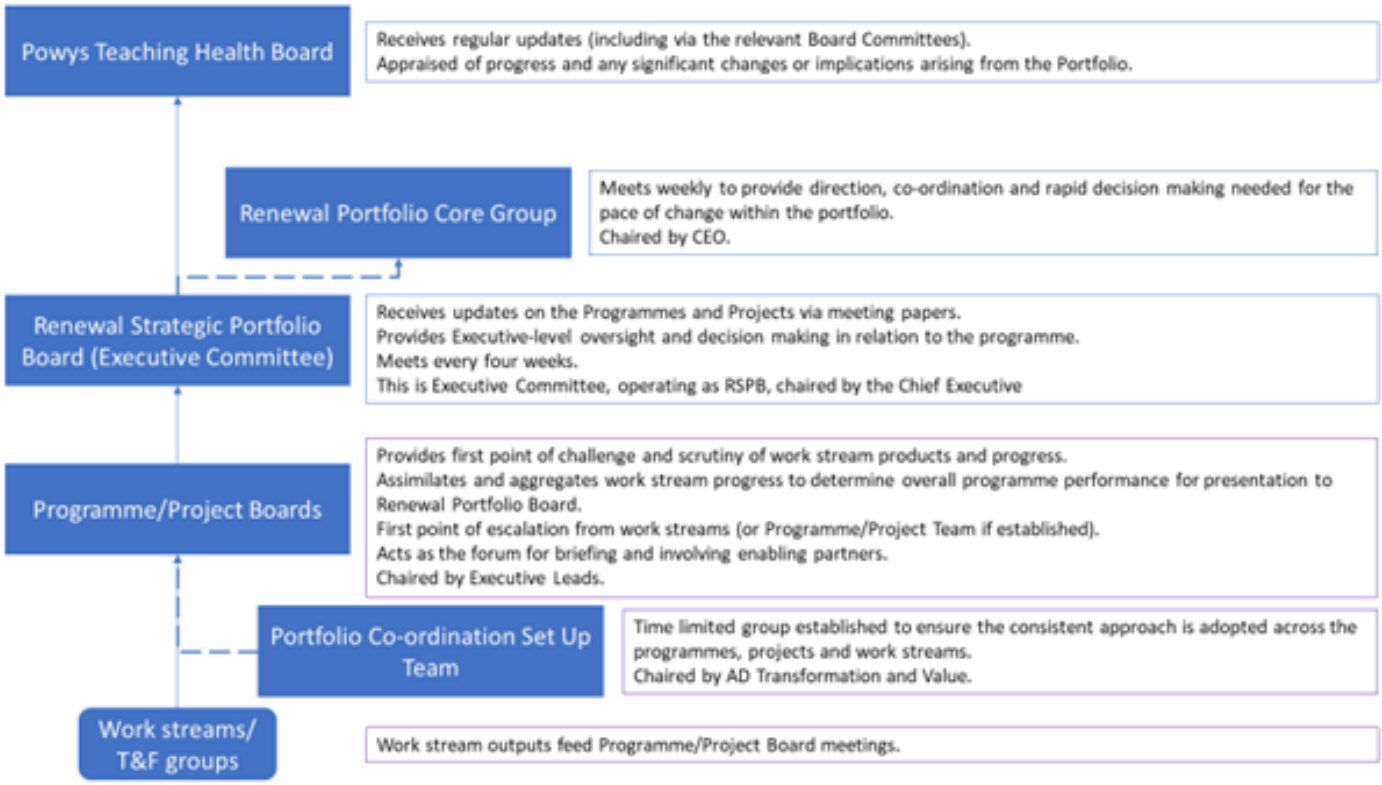
18 Independent members were consulted upon the development of the renewal portfolio as it was also included as part of the development of the 2021-22 Annual Plan agreed in June 2021. However, part of the role of independent members is strategic development and had they been involved at an earlier stage, this would have resulted in more ownership, knowledge and challenge of the renewal portfolio which drives improvement. Since this time there has been a change in the independent member cadre. The Health Board should therefore take the

opportunity to refresh the awareness of independent members of the portfolio **(Recommendation 1).**

Effective arrangements are in place to deliver the planned strategic renewal portfolio priorities, with some notable successes however governance structures are disproportionately large, and recruitment remains challenging

19 The Health Board has established a robust governance structure for the operational day to day running of the programmes/projects which exist under each priority, and effective oversight of the strategic renewal portfolio is in place. This is outlined in **Exhibit 2**.

Exhibit 2: Renewal Portfolio Governance Structure



Source: Powys Teaching Health Board

20 The Renewal Strategic Portfolio Board (RSPB) was established at the end of Quarter 1 2021-22. The RSPB is made up of the Executive Committee and is

chaired by the Chief Executive. The RSPB meets four weekly and provides oversight and decision making.

21 There is also a Renewal Portfolio Core Group (RPCG) meeting weekly to drive rapid decision making and direction to maintain the pace of change desired. The Chief Executive also chairs this group.

22 Both groups have operated well, however, the Health Board may wish to consider whether governance and scrutiny would be improved by the Chief Executive not acting as chair for both groups. This could enable better delegation and ownership to senior executives and allow the Chief Executive and independent members to challenge senior executives more effectively and independently. **(Recommendation 2)**

23 As described in **Exhibit 2,** each priority sitting underneath the strategic renewal portfolio has a programme or project board, and these have met routinely. These programme/project boards are chaired by the nominated executive lead for that priority. Agendas and papers are available and describe the work of the programme/project. The programmes are supported by risk registers and action logs, as well as detailed project plans which outline the activities. Risks that are identified by the renewal programmes/projects are escalated to the RSPB. Staffing challenges feature on both the programme/project and strategic renewal portfolio risk registers. There are plans in place to try to develop more creative workforce models to address capacity gaps.

24 The Health Board has used some of the additional monies received from the Welsh Government to support recovery from the COVID-19 pandemic[1] to recruit two transformation managers (two were already in post), who support the operational teams in transforming ways of working. The Health Board has since funded these substantively and they are now permanent staff members who will effectively support operational teams to make changes and develop new ways of working. The positive investment in these resources will help support the strategic objectives of the Health Board longer term.

25 The work contained within the renewal portfolio covers a broad spectrum of the Health Board business but within it are specific programmes/projects. The scale of these programmes/projects is reflected in the monies allocated which overall is only a small proportion of the Health Board's global budget. Conversely the governance infrastructure is substantial and has added a number of additional meetings to diaries which could create additional work for staff members in relation to reporting and attendance at meetings, who are already under significant pressure. There is an opportunity for the Health Board to review the governance structures and assess whether the arrangements are disproportionate to the current scale of work which is being delivered within them. There could be scope

[1] The Health Board received a total of £3 million additional monies to support recovery from the COVID-19 pandemic.

for the existing governance structures to support other projects, such as the wider delivery of the Integrated Medium-Term Plan (IMTP) **(Recommendation 3)**

26 The renewal portfolio is intended to redesign and provide whole pathway transformational change to the areas identified within it. There is acknowledgment that there are differing timescales for the work under the renewal portfolio and that whilst some aspects will be achieved quickly, some will take long term transformational change. This is clearly articulated in the Health Board's 2022-2025 IMTP.

27 Although the renewal portfolio was started in June 2021, there has been some delays in delivery and progress due to the unprecedented demand of COVID-19 and the Health Board's need to respond including the mass vaccination effort during winter 2021. Recruitment to posts needed within the strategic renewal portfolio however has been the main barrier, and the analysis of spend to date show that recruitment delays or inability to recruit is the main issue. The short term and non-recurrent nature of some funding has also been a barrier.

28 Despite the challenges, reporting has been undertaken in line with the governance requirements and work is underway in a range of projects which have already shown progress, particularly within the 'Breathe Well' priority. The latest May 2022 update to the Delivery and Performance Committee of the Health Board outlined several achievements including in-sourcing additional capacity for pre-operative assessment, and outpatient appointments in general surgery, oral surgery, and endoscopy. There were other achievements such as the establishment of the cancer renewal team, and appointment of the clinical lead and cancer tracker. A clinical led harm review panel for cancer breaches has also been established.

29 The Health Board are constantly reflecting on the design of the renewal portfolio which is developing as work progresses. As mentioned previously, the long-term conditions priority was removed from the overall renewal portfolio due to scoping challenges. This allows the project to be agile, however this agility needs to be carefully managed as there is a risk that the portfolio loses sight of its core objectives. **(Recommendation 4)**

Arrangements for monitoring and providing assurance on delivery of the strategic renewal programme need to be strengthened

30 When established, each renewal priority area had its own Project Initiation Document (PID) with a set of year one milestones. The progress against these milestones has been reported to the Renewal Strategic Portfolio Board as well as updates provided to the Health Board's Delivery and Performance Committee and Board.

31 In the performance report section of the Annual Report 21-22 presented to the Delivery and Performance Committee in May 2022, there is a section on renewal.

This provides helpful narrative updates in relation to each priority with 'Key Points of Progress.'

32 The updates also include the intended key outcome measures, although it is not clear from the current position whether the renewal priorities are on track to deliver those outcomes. Since our work, the outcome measures have now been amalgamated into the 2022-2025 IMTP, and the renewal priorities now underpin the strategic priorities and key actions in the delivery plan which supports the IMTP.

33 The May 2022 meeting of the Delivery and Performance Committee also had the 'Overview of Renewal Strategic Portfolio Developments' report. The key actions are listed and beneath is a narrative setting out what has been achieved. Whilst the narrative is useful to understand activity, it has no tracker to establish whether those achievements have moved forward the project. There is also another section setting out the expected milestones by the Welsh Government of the Health Board's recovery proposals, with columns for activity undertaken and current position. Again, it is unclear how these link to the key actions of the respective portfolio area.

34 Going forward the Health Board has developed a maturity matrix[2] (based on a scale of 1-5) to help assess the development of the programmes over the next three years. In May 2022, the Health Board assessed its programmes against this matrix, and all were around level 2 or 3, except for the 'Breathe Well' priority with a score of 3-4 and the 'Mental Health' priority which had yet to be assessed.

35 Whilst the maturity matrix is a welcome assessment, updates would benefit from a tracker which showed actual progress against planned activity and a RAG rating which would be helpful to assess momentum and success. Reporting would also benefit from clarity around the key actions and what impact they will have. It is currently difficult to tell whether the current actions are the right ones to support the measures and the golden thread from activities to key actions to strategic objectives is not apparent. This would also demonstrate how the work relates to the wider IMTP and strategic direction. Reporting could then be lifted a level with the assurance that the operational work has smart links to strategic vision. This would also enable better scrutiny and challenge. **(Recommendation 5)**

[2] The maturity matrix is based on a scale of 1-5 and considers five aspects of the programme - purpose and governance, process, collaboration, outcomes, and future development.

Appendix 1

Organisational response to audit recommendations

[**Appendix 1** will be completed once the relevant committee has considered the report and organisational response.]

Exhibit 3: Organisational response

Recommendation	Organisational response	Completion date	Responsible officer
Independent member oversight 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			

Recommendation	Organisational response	Completion date	Responsible officer
continued ownership, knowledge, and challenge.			
Chairing 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.			

Recommendation	Organisational response	Completion date	Responsible officer
Governance Structures 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.			
Renewal Portfolio Scope Creep 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.			

Recommendation	Organisational response	Completion date	Responsible officer
Delivery monitoring 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.			

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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.

Organisational response

Report title: Review of the Strategic Renewal Portfolio – Powys Teaching Health Board

Completion date:

Document reference: 3320A2022

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R1	**Independent member oversight** 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.	No	Yes	There is an induction process for new Independent Members, including meeting lead Executive Directors and other officers involved in renewal programmes. Regular papers have been submitted to the Board and Committees of the Board on the progress of the renewal portfolio and individual programmes, in accordance with the Board work programme, providing an opportunity for new and existing Members' continued ownership, knowledge and challenge. There has also been relevant discussion within informal Board development sessions. Progress against deliverables identified in the IMTP are reported to the Delivery and Performance Committee and Board on a quarterly basis. Thus, via the induction process, regular updates to the Board, IMTP reporting and informal Board development sessions Independent Member awareness has been refreshed.	December 2022 Complete	CEO

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R2	**Chairing** 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.	Yes	No	The renewal portfolio was established at pace, in order to meet the challenges of recovery and renewal arising from the pandemic. Earlier waves of the pandemic resulted in work needing to be undertaken in some instances in very short timescales. The Core Group, chaired by the Chief Executive Officer, was covered in the approved Portfolio Initiation Document and ensured strengthened governance where, for example, responses were required to Welsh Government in less than a working week which would otherwise would have resulted in individual officers having to respond. The Core Group was not dislocated from the strategic portfolio board and hence they were both chaired by the CEO for continuity. Since the fieldwork in March 2022 governance arrangements have had to be further amended to ensure an agile and appropriate response to the differing phases of recovery needed. The Core Group is no longer meeting and it has not met since September 2022. The renewal portfolio board is now incorporated into the Executive Committee Transformation and Value group.	September 2022 Complete	CEO
R3	**Governance Structures**	Yes	No	The fieldwork was undertaken in March 2022 when a number of programmes which	October 2022 (complete	CEO

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
	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.			were relatively new had to be suspended in order to respond to mass vaccination and the Omicron variant, for example, the work in relation to insourcing to address the planned care backlog in Powys had been ready to start in December 2021, but then had to be urgently deferred to Q4 due to Omicron. It was subsequently re-established successfully but work had to continue into Q1 2022. As reported to the Board and its committees the work of the renewal portfolio has subsequently included successfully addressing backlogs in Powys related to endoscopy and day surgery using insourcing; a clinical cancer lead was secured; FIT testing was successfully rolled out for the whole of primary care in Powys, for which internal audit found there was substantial assurance; access to rapid diagnostic centres was extended; a draft diagnostic strategic intent has been developed; work has been taken forward to respond to Getting It Right First Time Reviews of planned care for orthopaedics, gynaecology and general surgery; all Powys patients on Powys waiting lists were contacted as part of work on advice, support and prehabilitation; work has been undertaken to prepare for new techniques such as transnasal endoscopy; a community cardiology pilot has beem implemented; work in relation to falls	with the establishment of the Transformation and Value Group of Executive Committee.)	

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
				pathway has been undertaken; drive through spirometry cleared a backlog of 141 patients and identified that a third of future referrals could be avoided; oxygen reviews were undertaken and 45% of patients had clinically inappropriate equipment removed; new physiology capacity and capital equipment was secured enabling the setting up of lung function testing and the repatriation of some sleep clinic activity; there was strengthening of respiratory MDT work resulting in 40% of a secondary care consultant backlog in relation to follow-up being addressed; virtual pulmonary rehabilitation was used successfully to address delays; cross cutting work on redesigning rehabilitation to join together a generic core with condition-specific elements was undertaken; and there has been significant progress in addressing the paediatric neurodevelopment backlog. As the renewal portfolio matured it has moved into whole system sustainability and there have been resulting changes to governance, including broadening the focus to the Transformation and Value Executive Committee.		
R4	**Scope Creep** The renewal portfolio is constantly being reviewed and developed, allowing for an	No	Yes	Individual programmes have Programme Initiation Documents and adhere to programme governance arrangements.	31st March 2023	CEO

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
	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.			However, there has been a need to respond to new requirements including from Welsh Government in the period. An action will be taken to ensure all Programme Initiation Documents are up to date by 31st March 2023.		
R5	**Delivery monitoring** 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.	Yes	Yes	At the time of the audit fieldwork a number of renewal programmes had been established less than six months and some were subject to ongoing disruption due to the Omicron variant. These factors impacted on the ability of the affected programmes to deliver planned activity and associated outcomes. This has predominantly been a timing issue as work undertaken after the field visit in March 2022 has shown demonstrable positive outcomes such as the insourcing undertaken under the Diagnostics, Ambulatory and Planned Care Programme; the work under the Breathe Well Programme including the modernisation of follow-up, virtual pulmonary rehabilitation; the clearance of the spirometry backlog, the oxygen reviews; and the roll out of FIT testing in Powys under the Cancer Programme. The IMTP delivery plan quarterly reporting process has been strengthened, including the relevant renewal actions, and includes	Complete October 2022	Executive Director Programme Leads

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
				RAG rating against delivery plan milestones.		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Audit Risk and Assurance Committee	**Date of Meeting: 31 January 2023**
Subject:	**Counter Fraud Update Report**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2022/23.
RECOMMENDATION(S):
It is recommended that the Audit Risk & Assurance Committee receive the report for discussion and note the content of this update report.

Ratification	**Discussion**	**Information**
	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	✓

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	✓				

Audit Risk and Assurance Committee

Item 3.6

Counter Fraud Update Report

31 January 2023

1. INTRODUCTION

The purpose of this report is to update the Audit Committee on key areas of work undertaken by the Health Board Local Counter Fraud Specialists since the last meeting.

2. BACKGROUND

Meetings are held on a regular basis with the Director of Finance, where progress against the annual work plan and with the LCFS case workload is discussed and monitored.

The following sets out activity under the Key Principles specified within the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below. Figures are correct as of 18 January 2023.

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	**35**	**29**
Inform and Involve	**70**	**47**
Prevent and Deter	**103**	**78**
Hold to Account	**100**	**90**
TOTAL	**308**	**244**

4. STRATEGIC GOVERNANCE

A meeting was held with the NHS Counter Fraud Authority Quality Assurance Inspector (QA Inspector) has confirmed that the Health Board has been selected to be reviewed. The QA Inspector reviewed outcomes of action plans set following previous Thematic Assessment of the former Standards 3.4,3.5 and 3.6 and Testing Fraud Risk Assessment and Local Proactive Exercises undertaken by the Counter Fraud Team.
The QA Inspector was satisfied with response to actions plans set out in previous Thematic Assessment.
Feedback was generally positive around risk assessment. The QA Inspector identified that language of completed risk assessments should be adjusted to ensure alignment with the GCFP methodology expected within the Counter Fraud Standards to overtly outline the Actor, Action and Outcome within summary of risks.
Additionally, the QA Inspector gave feedback that recording of risks should align to

the Health Board arrangements. Discussions with Governance & Risk colleagues will be undertaken to establish best practice for recording in line with Health Board expectations.
Feedback around Local Proactive Exercises (LPEs) was generally given on an All-Wales basis to ensure that Counter Fraud Teams actively record work as LPEs on the system. A review will be undertaken to ensure all previous proactive work that meets the NHS Counter Fraud Authority definition of an LPE is retrospectively recorded on the Clue system.

The Counter Fraud Team attended an All-Wales Counter Fraud Forum held by Counter Fraud Service Wales in conjunction with NHS Counter Fraud Authority. The Forum covered an update in training around aspects of changes in evidence disclosure, pre charge bail and examination of electronic devices introduced by the Police, Crime, Sentencing and Courts Act 2022. Information was given on plans to develop a new approach to counter fraud intelligence utilising the case management system Clue3 which is to be trialled in NHS Wales. An update from Quality and Assurance Inspectors was also given with a report to be issued imminently following their inspection visit to NHS Wales in September.
As well as operational updates information was provided of an organisational 'evolution' being undertaken within NHS Counter Fraud Authority. This is essentially a staffing, strategy and organisational review and restructure. There are to be no job losses in this exercise and impact on NHS Wales counter fraud teams will be minimal.

A meeting has been held with the new Local Counter Fraud Specialist at NWSSP. The Organisation previously had part FTE arrangement with Cardiff and Vale UHB; the new LCFS is a full-time appointment solely focused on NWSSP fraud work. This will be a useful link to work cross functionally with on issues arising in particular risk areas where NWSSP provide services to the Health Board. A data sharing agreement is being produced to ease future working with this new contact.

A statistical analysis of performance against key performance indicators has been produced and at Appendix 1 to this report. The analysis measures Health Board performance against an all Wales benchmark average to provide greater context to the statistical information.

5. INFORM AND INVOLVE

As detailed within the agreed Counter Fraud Work Plan, an on-going programme of work has been put in place to raise awareness of fraud, bribery and corruption amongst all staff and practitioners across all sites. A programme of awareness sessions have been established for 2022/23 and these dates are being offered to staff to self-book onto counter fraud learning. The Counter Fraud Team now also have a slot to delivery training as part of the Health Board's Managers

The Counter Fraud Team participated in International Fraud Awareness Week which ran 13-19 November. A series of articles and communications around NHS fraud risk were disseminated throughout the week. NHS Counter Fraud Authority further

supported the event through issue of fraud awareness materials such as branded pens, notepads, keyring torches. The Counter Fraud Team conducted site visits to deliver promotional materials and issue a special edition newsletter via Post Rooms.

The Counter Fraud Team have engaged Primary Care to establish a fraud awareness programme aimed at GMS contractors. The awareness programme is being instigated due to recent issues identified affecting GP Practices. These include recent conviction of a Practice Manager for fraud offences, an exercise undertaken assessing risk relating to GP Patient Registrations following conviction of an individual accessing controlled drugs for resale via registering as a temporary patient along the M4 corridor. The programme will focus on risks arising from these issues as well as general fraud awareness around known fraud risks such as empty box fraud, mandate fraud and false invoicing.

6. PREVENT AND DETER

The Counter Fraud Team have undertaken a proactive exercise around compliance with the Health Board's Standards of Behaviour Policy specifically focussing on compliance with declaration of gifts, hospitality, sponsorship, and external interests covered by that Policy. The exercise utilised data from the Health Board's National Fraud Initiative datasets which show employees with external interests in secondary employment roles or businesses for which the Health Board has engaged for supply of goods and/or services. A full report containing findings for this exercise is at Appendix 2 to this report.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix 3 to the report. A summary of basic investigation KPI data is presented at outset of the appendix.

Case information presented is split by between those cases which are currently open and under active investigation by the LCFS; contained in the Open Cases table.

The Pending Cases table reflects those cases where active investigation by the LCFS has concluded, however the case must remain open due to other outstanding actions from third parties such as (but not limited to) disciplinary, professional body enquiries, financial recoveries.

A table of Closed Cases is also presented to review outcomes of investigations.

8. RECOMMENDATION

The Audit Committee is asked to **note** the Counter Fraud Progress Report.

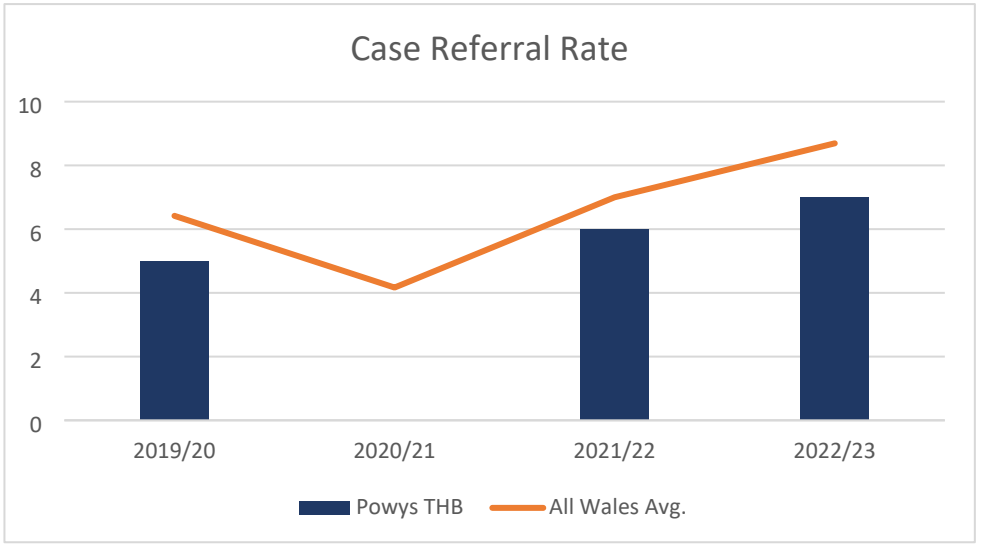
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

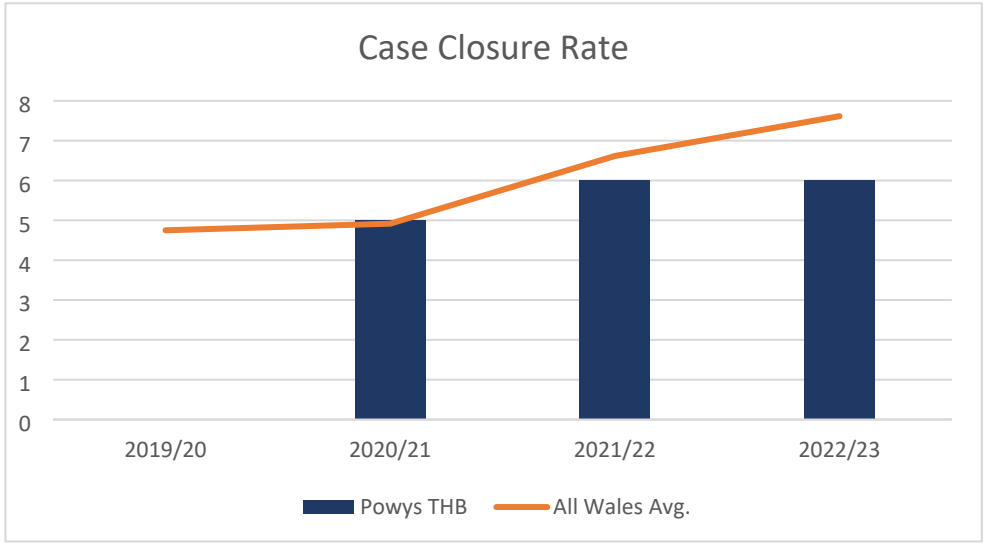
Item 3.6

Counter Fraud Benchmark Statistical Analysis

Counter Fraud Awareness Statistics – Half Year

Case Referral Rate	Powys THB	All Wales Avg.
Case Closure Rate	Powys THB	All Wales Avg.
~~2019/20~~ ~~2020/21~~	~~5~~ ~~6~~	~~4.8~~ ~~4.3~~
~~2020/21~~ ~~2021/22~~	~~6~~ ~~5~~	~~4.9~~ ~~7.0~~
~~2021/22~~ ~~2022/23~~	~~6~~ ~~7~~	~~6.6~~ ~~8.7~~
2022/23	6	7.6





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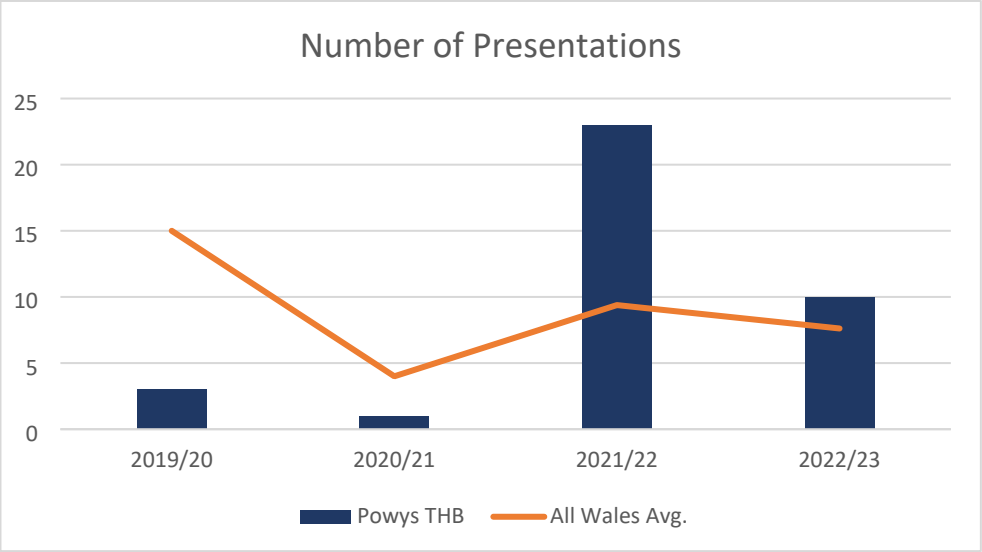
Counter Fraud Awareness Statistics – Half Year

Investigation Progression Rate	Cases Open at Start of FY	Referrals Received	Cases Closed	Total Cases Open End of Period
2019/20	9	5	0	14
2020/21	14	0	5	9
2021/22	6	6	6	6
2022/23	3	7	6	4

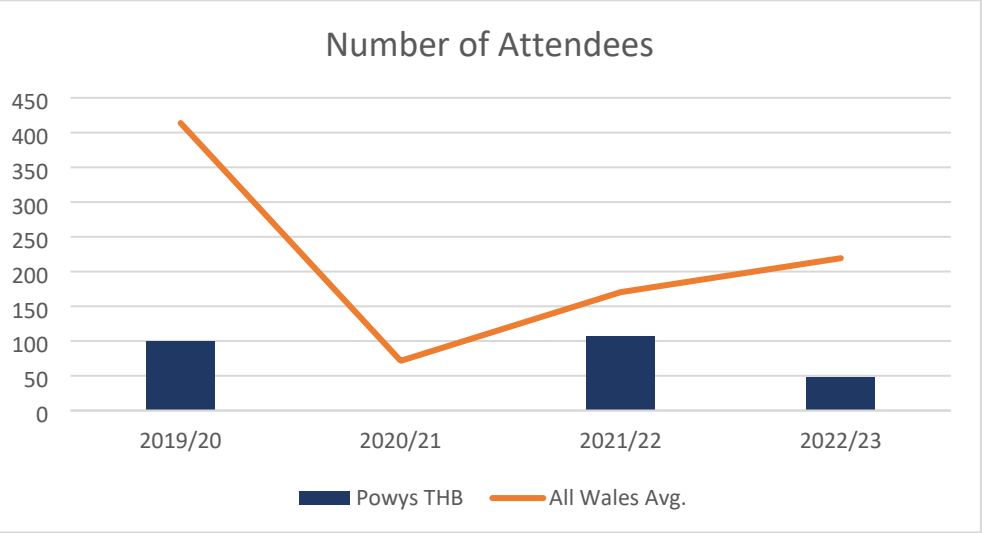
Sanctions	2019/20			2020/21			2021/22			2022/23		
	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil	Criminal	Disp	Civil
Powys THB	0	0	0	0	1	0	0	0	0	0	0	0
All Wales Avg.	0.6	1.4	1.6	0.3	1.0	1.2	0.4	2.3	1.6	0.3	1.3	1.9
All Wales Total	7	17	19	4	12	14	5	30	21	4	17	25

Counter Fraud Awareness Statistics – Half Year

Number of Presentations	Powys THB	All Wales Avg.
2019/20	3	15
2020/21	1	4
2021/22	23	9
2022/23	10	8

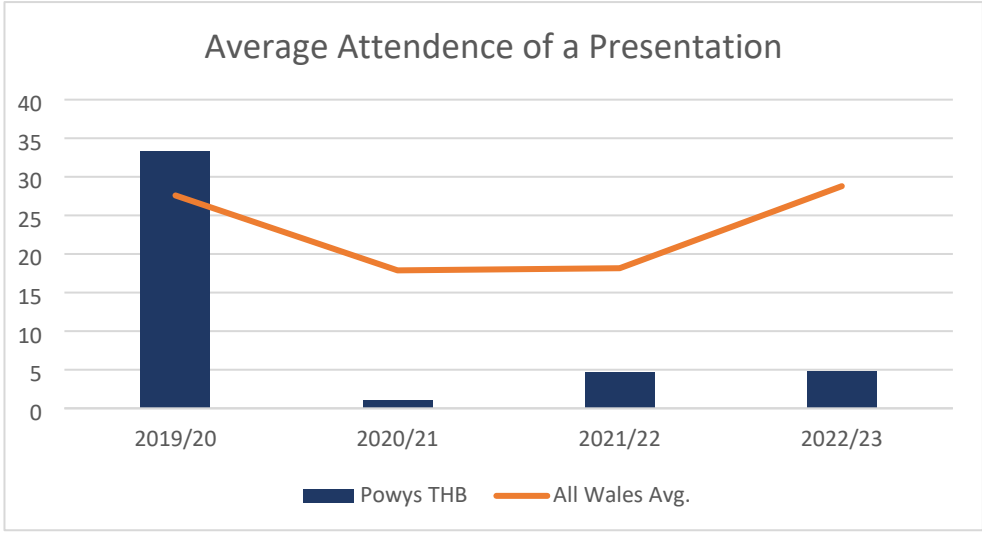


Number of Attendees	Powys THB	All Wales Avg.
2019/20	100	414
2020/21	1	72
2021/22	107	170
2022/23	48	219

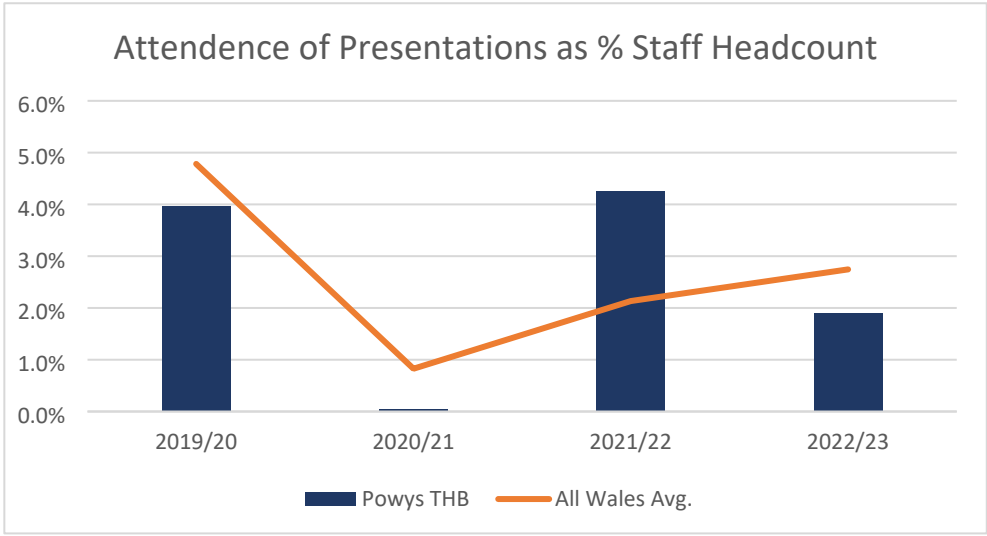


Counter Fraud Awareness Statistics – Half Year

Average Attendance of a Presentation	Powys THB	All Wales Avg.
2019/20	33	28
2020/21	1	18
2021/22	5	18
2022/23	5	29



Attendance of Presentations as % Staff Headcount	Powys THB	All Wales Avg.
2019/20	4.0%	5%
2020/21	0.0%	0.8%
2021/22	4.3%	2.1%
2022/23	1.9%	3%



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

COUNTER FRAUD, BRIBERY & CORRUPTION

Proactive Exercise

Gifts & Hospitality
And
Declarations of Interest

January 2023

Executive Summary

In response to an identified concern the Local Counter Fraud Specialist (LCFS) has undertaken an exercise to identify ways in which the Health Board can further strengthen mechanisms for recording and reporting gifts, hospitality, sponsorship, and external interests, within Powys Teaching Health Board (PTHB). The concerns were because of a number of LCFS investigations that took place as well as availability of National Fraud Initiative (NFI) data which indicated that there were staff members within PTHB that had undeclared roles outside of their substantive Powys role.

The LCFS established that there is a good level of compliance with staff recording gifts and hospitalities, and the entries placed on registers were at a high during 2020. This high volume of entries was likely due to the Charity department pro-actively seeking out reports of gifts and recording them on a separate register. In the years preceding 2020 and post covid-19 pandemic, there are a much smaller number of entries made on the Corporate Governance gifts register yet gifts were still being declared on the Datix system. The figures analysed by the LCFS demonstrate that staff are keen to record the gifts they receive but are using other means to record them as opposed to the correct procedure described in the policy. It was also discovered that there were three different gifts registers in use during April 2020 to March 2022.

The policy that covers declarations of interests and registering of gifts and hospitalities is clear in its explanations of what constitutes a gift or interest, and that they need to be recorded. The policy also stipulates the correct process for registering gifts and interests, however, staff appear to be unclear about how to report gifts and hospitalities as there are 3 different ways to register a gift being utilised within the Health Board, each with a different authorisation process. Interrogation of these different registers found that staff are preferring to declare a gift with no written authorisation being sought. The declaration of interest's form requires multi-level authorisation prior to submission, but there is also the ability to make a declaration via ESR. This new ESR function is still under review by Corporate Governance yet, has been used by some staff members to make new declarations.

At the conclusion of the exercise the LCFS found that there was a need for some improvements and has made recommendations to amend the process around making declarations, the most important being self-service ESR submissions.

Introduction and Background

The Board within PTHB identified a need to further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship as part of its annual governance review. In order to achieve this objective, the Board plan to:

- Embed the Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee

- Fully implement an electronic system to support recording and reporting of declarations made

The Local Counter Fraud Specialist (LCFS) therefore proposed to undertake a proactive exercise to identify any obstacles to reporting and recording, or any areas of non-compliance that need to be addressed.

Scope of Exercise

The exercise looked at the previous year's registers in order to gain an insight into the reporting trends for Powys, and to allow comparisons to be made with post pandemic reporting.

The declarations of interest register was also consulted in order to gain an insight into how widespread the reporting of outside interests is within PTHB.

Method

The LCFS liaised with the Board Secretary to establish when the Standards of Behaviour Policy was last reviewed and updated around gifts and hospitality. It was last reviewed in June 2019, and as such will face review again in June 2022. Although the policy has been readily available on the intranet, there have been no supporting communications around the topic of gifts, hospitality or declarations of interests, directed towards non-Board member staff by the Corporate Governance team for some time. The Counter Fraud department have provided awareness of these topics through several different forms of training. Communication with Board members by Corporate Governance, regarding the submission of annual declarations have been maintained.

The LCFS was provided with the declaration of interests registers for staff and Board Members for 2020/21, 2021/22 and 2022/23, along with the gifts and hospitality register for 2017/18 and 2018/19, the community gifts register for 2020/21 and 2021/22 and the Datix register of "compliments" for 2018-2022 which also included gifts

The gifts and hospitality registers were compared against each other to analyse any trends in reporting over the previous 5 years. This was to allow comparisons to be made pre-covid, during the pandemic and post-covid. The period covered by each register was noted as well as the number of entries on each register. The value of the gifts received in each entry were reviewed and the person making the entry was observed to see if there were any trends for which departments were better at reporting gifts.

The National Fraud Initiative exercise was also utilised to identify any declarations of interest that appeared in the data match exercise yet were not declared on the declaration of interests register. The NFI report provides the name of the PTHB staff member and the details of any company or business they are linked to, or any invoices paid by PTHB on which their name also appears. The name of the staff member was provided to the

Corporate Governance Team who checked the declaration of interests register to confirm if the business had been declared by the employee.

Findings

Gifts & Hospitalities

The gift and hospitality register for 2017/18 was dated January 2017 to December 2017, covering a 12-month period. During that time there were 11 declarations recorded by 8 members of staff. All of the gifts were accepted, and there was nothing recorded with an outcome of "declined". The gifts varied in value, from £4 at the lowest, to £6000 at the highest. There was a gap between December 2017 to April 2018 when the next entry of a gift was made; it is unknown whether this was due to no gifts being received or declared, or whether a move from covering a calendar year to covering a financial year meant there was no register being maintained.

The register of gifts and hospitality for 2018/19 was dated from April 2018 to September 2018 and contained only four entries. All four entries were made by different staff members, and the value of gifts ranged from £10 to £100. Again, no records were made of offers that were declined. As the Corporate Governance team are all new in post since this register was in use, it is not known whether there were declarations of gifts post September 2018, or whether there is another reason for nothing to be noted on the register.

The register for 2019/20 contained one entry, made in August 2019. No other records of gifts or hospitalities were made on the Corporate Governance gift register.

For the financial year commencing April 2020 there was no gift register held by the Corporate Governance team; the reason for this is due to no declarations being made by staff via the normal channels in light of the pandemic. There was a "community gift register" being maintained by the Charity department at the time, who had been tasked by Corporate Governance to maintain a formal register of all gifts declared via other means. In September 2020 guidance was sent out to staff which referred to the Standards of Behaviour policy but reaffirmed that gifts up to the value of £25 did not need to be declared.

The community register for 2020/21 covered April 2020 to March 2021 and saw a vast increase in entries; there were 115 entries recorded by staff members from across the health board. The value of the gifts was not included, with the entry being marked yes or no if the gift exceeded £25. There were 26 entries contained on the register where the value was confirmed to have exceeded £25. Of these, 23 of them were gifts to be shared amongst several staff or patients on a ward, thereby likely bringing the value per person down to under £25. This gift register was in use at the height of the Covid-19 pandemic, which saw members of the public showering gifts on NHS staff as a way of thanks for their service. There was one entry of a gift that was declined; all other

entries were accepted gifts. Most of the declarations were made on Facebook and recorded on the register separately. For the beginning of the year the records are vast, with up to 17 entries being made on any one day, however after June 2020 this decreased drastically with only a few gifts being recorded across the whole of a month.

The community gifts register and was completed by the Charity Manager and his admin support and held locally by them. To populate the register, the Charity team were manually searching Powys announcements and the Stay Well in PTHB Facebook group for any posts that described a gift being received. They obtained the relevant details about the giftee and estimated the value of the gift using details from the post itself and used that information to populate the register. Very few entries on this register came as a result of staff members completing the gifts and hospitalities submission form.
The 2021/22 community gifts register covers the period April 2021 to March 2022 and holds 15 entries, dated between June 2021 and December 2021. The lack of entries on either side of this time frame is due to there being no posts on Powys announcements or the Stay Well in PTHB Facebook page for the team to record. On this register there were only two entries that made observations about the value of the gift, with notes stating that the combined value was over £25 but per person was under the threshold. There were no gifts recorded as declined, again due to this being a pro-active exercise by the Charities department as opposed to staff submissions.

The final means of submitting a declaration of gifts and hospitality was via the Datix system. This register is held and controlled by the Quality and Safety Team, although limited members of the Corporate Governance Team do have access to view the list. This list has been in operation since 2018 and allows staff to self-record a "compliment", be this a card or letter. When making an entry the staff member will utilise a drop-down menu and make selections from pre-determined options. These options include flowers, gifts, food & drink, and cards.

Between September 2018, when the Datix system was first tested for this function, to the end of March 2019 there were 111 entries of gifts or hospitalities, which also included cash. No gift was recorded as being declined.

Between April 2019 to March 2020 there were a total of 277 gifts recorded on the Datix system, falling into the same categories as the previous year. Worryingly there were also entries that described cash and cheques being received and accepted, but not forwarded to the charitable funds. This is contrary to the Standards of Behaviour policy.

Between April 2020 and March 2021 there were 70 entries of gifts, flowers, food and drink, or cash/cheque placed onto Datix.

Between April 2021 and June 2021 there were 8 further declarations of gifts being received, before the facility for staff to record them via this means was removed by the Quality and Safety Team. At this time Datix was moved to the new 'Once for Wales' system and initially the permissions for staff to record gifts on this platform was granted; however due to similar submissions being made on the new system, the

Quality and Safety Team removed the permission for staff to record such entries. In the time period between June 2021 to March 2022 while staff had the ability to record gifts on the new Once for Wales system there were 81 entries of gifts, flowers, food and drink or cash/cheques being received. Of all the entries made between September 2018 to March 2022 there was only one record of a gift being declined, all others were accepted.

The Quality and Safety Team have provided training to staff regarding the use of Datix and Once for Wales to record compliments, as a means of seeing good work being done, however they advise that they have never instructed staff that this is the preferred means of submitting a record of a gift, nor have they directed staff to complete this step but not complete the procedure as described within the Standards of Behaviour Policy.

While the Datix feature was being used by staff the Corporate Governance Team were unaware that this was the method most widely used to register gifts, and it only came to light when a member of staff was asked to complete the excel form to register a gift but indicated that they had already done so via Datix.

Submission Forms

To submit a record of a gift or hospitality to the register, in accordance with the policy, the staff member must complete an excel form, save a copy prior to requesting Director approval with a final submission to the Corporate Governance Team. This then gets forwarded to the Corporate Governance Team for inclusion on the register. In cases where staff don't have access to laptops or desktops, they can complete a hard copy of the form in a word document format. This is then signed and scanned by their director and sent as a PDF to Corporate Governance for inclusion on the register. This means there are currently two ways to submit a record of a gift or hospitality. The Corporate Governance Team are exploring an alternative format at present, whereby all previous excel forms will be removed, and staff will be directed to complete an online "Microsoft forms" link. There will still be the ability to complete a hard copy of a Microsoft document and scan it in, as this allows new staff without online access, or staff that do not have regular access to laptops, to still make submissions.

The other means of submitting gifts are not approved within the policy, however, to make a Datix entry the staff member is required to verbally speak with their line manager about any gift, and complete the Datix form online, recording notes about who they spoke with.
The permission for staff to do this has been removed since March 2022, therefore staff can no longer use this for submissions.

For inclusion on the community gifts register the staff member merely makes a Facebook post on the Stay Well in PTHB group age or places an entry on the PTHB announcements and the Charity Team will record it on their behalf. For either of these types of declaration there is no requirement to have written approval from a director, and therefore is not compliant with the policy.
Since January 2021, as part of the counter fraud objective to increase fraud awareness, the LCFS has given an input at all the induction sessions for new health

board employees. The input is an introduction to what fraud is, how to spot it, and where to report it; but attention is drawn specifically to the requirement to record gifts, hospitality, and declarations of interest. Between January 2021 to January 2022 a total of 134 staff have attended the inductions and been provided the relevant information as well as signposting on where to access the registers to facilitate the recording of gifts, hospitality, and declarations.

Declaration of Interests

The declarations of interests' registers for Board members between 2018-2021 were reviewed for entries. The Corporate Governance Manager indicated that on an annual basis, members of the board and Directors were asked directly if they had any new entries or updates to make. The records reviewed showed that the board members have a high level of compliance with the policy. The register shows both the board member themselves and their spouse or family interests. Those that made declarations in 2018 and are still present at PTHB maintain their declarations on each consecutive register, indicating that they renew their declarations as is expected of staff. They also record 'nil declarations' on the register.

In relation to staff that are non-board members, when they make a declaration of interest the information is recorded on a separate declaration of interest register to that of the board members. The past three staff declaration of interest registers were provided, dating from 2020 to present. In 2020/21 there were two declarations from staff members. The following year, 2021/22 saw an increase to seven declarations, which included 4 that came via ESR submission. So far in the 2022/23 register there have been four declarations made. The increase in reporting coincides with the Counter Fraud objective to increase awareness by educating new staff at mandatory inductions.

The LCFS explored the reason for holding two lists, one for Board members and one for non-Board member staff; the reason being that the Board member list is published in an annual report, which is also made public, where the staff declarations list is not.

The process for non-board staff members to submit a declaration of interest is for them to complete an excel document and submit it to their line manager. Once signed by the line manager the department Director will also sign the form for submission to the Corporate Governance Team. This allows opportunities for conversations to be had with the staff member if there is deemed to be a conflict of interest. As with declarations of gifts, there is also a Word document copy of the form that can be completed and submitted. Corporate Governance are currently exploring the option to utilise a Microsoft
Forms link for such submissions until such time as ESR has the functionality for staff to submit their declarations. They will however maintain a Word copy of the document for use by new starters that don't have access to ESR, so declarations can still be captured at the earliest opportunity. There is work ongoing in conjunction with Workforce and OD to explore the ESR capability to accept new declarations of interest and the frequency that staff will be asked to submit such information.

LCFS Caseload

The National Fraud Initiative, or NFI, is a biennial data match exercise that sees agencies share information on staff and their earnings. This data is then used to match potential fraud offences where someone may have used their personal data on two sources of income, pensions, directorships, invoices and so on. The information is reviewed by the organisation, and in the case of PTHB, by the LCFS, to ascertain if there are any staff that may be committing fraud. The 2020/21 exercise saw several matches in each category, including 55 entries where the person had two incomes/jobs. In certain circumstances a follow up was made by the LCFS and the subject was advised that they needed to complete a declaration of interest form.

Between the 6-month period of August 2021 – January 2022, the LCFS investigated and/or concluded four cases where the subject was working whilst on sick leave, and none of the secondary employments were registered as a declaration of interest. In each case the line manager for the subject knew of the secondary employment but had not known or checked whether a declaration of interest form had been completed. Again, each subject and line manager were provided with advice by the LCFS about the completion of these documents.

As a result of the findings above the LCFS requested a message to be sent out on the staff payslips in March 2022 that provided an information message about having a second job/business and the need to complete a declarations of interest form as per the

policy guidelines. In direct response to that payslip message the LCFS received 6 emails from staff that wanted to report their second job/bank staff post. In each case they were directed to complete the online intranet form and submit it to the Corporate Governance Manager.

The policy that covers these topics is the Standards of Behaviour policy, due for review in June 2022. Within the policy there are four sections that explain the expectations on all staff around registering of interests, gifts, hospitality, honoraria and sponsorship. There are links within the policy to the relevant registers and definitions as to what constitutes each item, as well as an explanation of bribery. There is also a warning with regards to the acceptance of gifts at the employee's own risk. Each section within the policy is broken down into sub-sections and gives examples of what can or cannot be accepted.

There is conflicting information in the policy. Section 7 gives an overview of gifts and hospitality, honoraria and sponsorship. This section states that staff have a personal responsibility to volunteer information regarding gifts and hospitalities, including offers that are declined. The policy states that approval is to be sought from a Department Executive/assistant Director prior to acceptance and the details must be recorded on the register. The section is then broken down into subsections and goes on to detail each type of benefit separately. Subsection 7.2 covers the requirements for declarations if the gift is from a service user or relative. This subsection states that there is no need to register a gift if it is valued under £25 unless there are a number of small gifts from the same source within a 12-month period, which would then take it

over the £25 threshold. This is also the guidance that was sent to staff during the pandemic

Comparison with the same policy document for Swansea Bay University Health Board (SBU) shows that much of the same guidance is adopted; the limit on value of gifts is £25, and in the first instance they should be declined. If they cannot be declined and are over £25 value they should be utilised for the benefit of charitable funds, such as a raffle etc. SBU also requires staff to obtain authorisation from the clinical lead/Director prior to acceptance of a gift, and a form must be completed. The Standards of behaviour policy for SBU contains a flow chart to help guide staff through the process of being offered a gift and what to do dependant on what the gift is. Their form for declaring gifts and hospitality requires both their line manager and the department director to sign prior to submission to Corporate Governance.

The SBU form to register a declaration of interest or secondary employment requires the line manager approval prior to submission to the Corporate Governance Team. There is no facility to record gifts via Datix within SBU.

Recommendations

The LCFS recommends some amendments and updates being made to the existing procedures:

1. This exercise as well as investigations conducted by the LCFS have highlighted that in cases where staff members have secondary employment/businesses, often their line manager is aware of this, and the declaration of interest form has not been completed as per the policy. Therefore, it is recommended that within the annual PADR review process the line manager is to ask their staff member directly about any other secondary roles/bank positions/businesses. This is more likely to capture up to date information about interests outside of PTHB and ensures that every member of staff within the Health Board is asked regularly during their career. This is currently being reviewed by Corporate Governance.

2. At present the declaration of interest forms are completed via the PTHB intranet page on excel spreadsheets which are then reviewed and authorised by the line manager and emailed to the Corporate Governance Manager. The Corporate Governance Manager then inputs the data onto a spreadsheet and maintains this each time a new submission is made. It is recommended that this process be moved to ESR self-serve, so staff can submit the information from their personal ESR account and update it at any time. This suggestion is also contained within the annual governance review, however, has not been carried out and will be rolled out during this financial year. There is an All-Wales approach being discussed regarding this and the capacity of ESR, and there appears to be limited capability already live. An All-Wales approach to this means of submission should be adopted by PTHB at the earliest opportunity and discussions are currently underway between Corporate Governance and WOD.

3. When registering a gift or hospitality the staff member must complete an excel form accessed via the PTHB intranet. The person completing the form is then instructed to save a copy and send it to the Corporate Governance Team once authorised by a Director/Assistant Director. The Director authorising is also asked to save a copy before submitting it to Corporate Governance. This is a very long-winded process and
not an efficient way to submit information to a register. It is recommended that this means of submission be simplified as it may be a barrier to recording gifts in its current format and may be the cause for a lack of registering of gifts and offers of gifts via the correct procedure, and why staff favour a Datix entry or Facebook post.

4 Overall, there seems to be a lack of clarity around whether gifts and hospitalities, or declarations of interests need to be declared and recorded. A program is currently ongoing whereby Counter Fraud are seeking to increase this knowledge, with staff being targeted at inductions, counter fraud awareness sessions and managers programs. It is recommended that other avenues of information sharing are explored, including the PTHB bulletin, payslip messages and advertising in staff areas, via means of posters etc. This is currently being explored by Corporate Governance.

5 When the Standards of Behaviour policy for PTHB is reviewed it is recommended that an easy-to-follow flow-chart be included, which staff can refer to in order to correctly register gifts, hospitalities and declarations according to the policy. This should also be placed in locations where staff see it often, as a means of communicating the correct procedure to staff. Corporate Governance are in the process of creating this.

Conclusion

Over the past few years, it is evident that the recording of gifts and hospitality is an activity that staff within PTHB are keen to complete, demonstrated by the numbers of declarations held across all the different lists maintained, however there appears to be a lack of knowledge about the correct process to do so. Other means of submitting a gift or hospitality have been utilised that fall outside of the policy and there are numerous registers sitting under different departments, which are conflicting with the policy.

In respect of Declaration of interest there is a clear lack of knowledge by staff and managers as to what is required of them, evidenced by the number of NFI matches and LCFS investigations where managers were aware of secondary roles held by their staff but did not take steps to ensure their staff had recorded them correctly.

The policy which covers these areas is due for imminent review but in its current format it is clear in its descriptions, aside from the contradiction already highlighted earlier in the report concerning gifts under the value of £25. Changes should be made to the submission forms, to make them more user friendly, and the use of alternative lists by departments other than Corporate Governance should cease. The addition of a simple

flow-chart may assist staff in knowing when and how to correctly submit information regarding gifts, hospitalities and declarations of interest.

The register of declarations of interest is held separately to the register for gifts and hospitality, and both are easily accessible to staff on the intranet. It is deemed that the form for declaring gifts and hospitality is a deterrent in that it asks staff to save a copy of the form, get it authorised by a director or Assistant Director, who is also asked to save a copy, before finally submitting it to the Corporate Governance Department. If this process was simplified it may create an increase in reporting of gifts and hospitalities, as was seen in 2020 when staff were listing their offerings on Facebook and someone else from within the Health Board took responsibility, separate to the giftee, for recording it on the register, as well as the number of Datix entries which do not require multi-level authorisations.

There is an ongoing program of work, conducted by the Counter Fraud department, to raise awareness of these topics and educate staff, both new and existing, of the importance of recording all offerings of gifts, hospitality, sponsorship, and declarations of interest. It is felt that more can be done to encourage staff to declare gifts, hospitalities and outside interests, with changes being suggested for an ESR self-serve function to allow staff to record declarations, as well as adding the question about outside interests to annual PADR reviews.

Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/21/00239	22/09/2021	Working whilst sick	Ex-Staff	Information that the subject was working at a local petrol station and café whilst on sick leave and receiving sick pay.	Investigation revealed that the subject had taken on a job whilst on sick leave, and then resigned from the health board after commencing in their new role. Following interview the subject admitted that there was a cross over period where they held two posts. Subject stated they were willing to repay any monies outstanding and arrangements are being made to recover funds.
INV/22/00921	20/07/2022	Timesheet	Agency	An agency worker is alleged to have claimed payment for hours not completed.	Evidence gathered that supported allegation. An interview was subsequently held with the subject who admitted to not working full hours claimed. Evidence was presented at interview which provided some mitigation including lack of guidance from employing agency around claims process and original job advert conflicting with contract between Health Board and Agency.
INV/22/01601	04/11/2022	Forgery of Health Board Letter	Patient	Allegation that a patient has amended an old PTHB headed letter from a staff member to obtain a benefit that they are not entitled to.	Enquiries established no NHS fraud or loss; Powys County Council are the potential victim and LCFS has worked to support their investigation into the matter.

Closed Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
INV/21/00078	04/06/2021	Overpayment of Salary	Ex-Staff	A final payment of salary at point of leaving Health Board employment was found to be potentially inflated.	This matter remained open while a dispute was ongoing between the subject and the Health Board. This matter is no longer being dealt with by Counter Fraud as there was no Fraud identified, merely a dispute. It is now deemed suitable to close the matter as WOD and Finance are dealing with the dispute.
INV/22/00490	04/04/2022	Overpayment Child Care Voucher Scheme	Ex-Staff	Following leaving employment with the Health Board the subject continued to receive child care voucher payments.	Enquiries established that no funds had been paid directly to the subject. The funds were traced to the child care provider via a third party payment processor. Recovery of the funds was undertaken following voluntary agreement.
INV/22/00624	01/06/2022	Abuse of position - contracts	Staff	Anonymous allegation relating to awarding of contracts to friends and social contacts.	A full review of the procurement processes was undertaken in relation to contracts awarded to named contractors. No issues were identified in the procurement processes and there was separation between the named subject and the contract award process. Findings were reviewed in full with CFS Wales Deputy Head who agreed no issues or concerns could be established in the award of contracts.
INV/22/00922	25/10/2022	Abuse of position - contracts	Staff	Concerns raised over the validation of high value invoices and other low value procurement contracts at Powys LHB.	Specific contract was provided by witness that was reviewed. Procurement processes were found to have been not followed but sign off was given at Executive level. A formal procurement process is now

Closed Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Outcome
					underway for this contract. Examples of high value invoices were reviewed and gaps in sign off process was found. Purchase and implementation of a digital system aimed at closing this gap is being considered. Despite findings of procedural failures no criminality was established. Fraud prevention recommendations have been made.
INV/22/01249	08/09/2022	Working Elsewhere Whilst Sick	Staff	Allegation that staff member has been working elsewhere whilst in receipt of occupational sick pay.	Enquiries established that staff member had volunteered at a music event during sick leave. Not suitable or proportionate to pursue via criminal investigation. Information shared with managers for consideration of disciplinary action.
INV/22/01250		Working Elsewhere Whilst Sick	Staff	Allegation that staff member has been working elsewhere whilst in receipt of occupational sick pay.	Following investigaiton no work elsewhere was established during sick leave periods.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

Audit and Assurance Committee	**Date of Meeting: 31st January 2023**
Subject :	Interim Report for Losses and Special Payments for the period 1st April 2022 to 31st October 2022
Approved and Presented by:	**Director of Finance & ICT**
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:
To provide the interim report of Losses and Special Payments for the period 1st April 2022 to 31st October 2022.
RECOMMENDATION(S):
The Audit Committee is asked to: Take assurance take assurance that losses and special payments for the period 1 April to 31 October 2022 have been managed as per the organisational policy.

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:

Losses and special payments are items that the Welsh Government would not have contemplated when they passed legislation or agreed funds for the NHS; such payments would also include any ex gratia payments made by the THB.

By their nature they are items which should be avoidable and should not arise. They are subject therefore to special control procedures and are included within a separate note in the THB's annual accounts.

DETAILED BACKGROUND AND ASSESSMENT:

The following relate to payments made on behalf of cases for which Powys THB have responsibility. Claims relating to the Residual Clinical Negligence (relating to former Health Authorities) cases are scrutinised by the Welsh Risk Pool advisory panel and therefore are not required to be included below.

The Audit Risk and Assurance Committee received an Annual report at its May 2022 meeting documenting Losses and Special payments made between the period 1st April 2021 to 31st March 2022.

This paper provides an interim report for the period 1st April 2022 to 31st October 2022.

The responsibility for managing Powys clinical negligence and personal injury claims transferred back to the Health Board in June 2012. This action brought together Concerns (incidents, complaints and claims [both <£25k and >£25k]) within the remit of the Concerns Team. The Redress, Compensation Claims & Inquest Case Co-Ordinator, manages the claims on a day-to-day basis supported by the Assistant Director Quality & Safety. Advice and support are provided by Legal & Risk Services on the processes and on the management of individual cases. Addressing learning following settlement of individual cases, learning and evidence is shared with Welsh Risk Pool (WRP) with the LFER process for reimbursement.

Systems and processes have been established and databases documenting all claims activity alongside the individual claims files exist. Decision making on payments are approved in a number of ways:

- On a day-to-day basis, advice received from Legal & Risk solicitors regarding payments are discussed with the Executive Director of Nursing & Midwifery. All discussions are documented in file notes to provide an audit trail for all decisions re: approved/ declined advice and subsequent transactions.
- The Management of Compensation Claims Clinical Negligence & Personal Injury Policy (April 2015) requires the Executive Team, as the delegated committee on behalf of the Board, to receive and review six-monthly progress reports on the management and status of claims against Powys Teaching Health Board (PTHB), as required under Section 8 of the Putting Things Right guidance. The last report provided to the Executive Team was October 2022. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety Committee (and the former Experience, Quality and Safety Committee). The last report was provided to the November 2022 Committee.
- Information and decision about Redress compensation claims <£25k have been channelled through the Putting Things Right Redress Panel. This allows the Panel to have an overview of all redress claims activity.

Clinical negligence and personal injury

In the period from the 1 April 2022 to 31 October 2022, the THB made payments in respect of 7 cases totalling £61,863.80 summarised below. It should be noted that the THB is responsible for the first £25,000 of any claim with the residual balance being covered by Welsh Risk Pool Services. During the year to date the THB has received one reimbursement in respect of cases that exceeded the £25,000 THB liability.

Details of the payments are included in **Appendix Ai**.

	No. of payments	No. of cases	£
Clinical Negligence /Personal Injury (Payment)	9	7	£61,863.80
Total	**9**	**7**	**£61,863.80**

There was one receipt from Welsh Risk Pool in respect of Clinical Negligence and Personal Injury cases over 25k during 1st April 2022 to 31st October 2022.

	No. of receipts	No. of cases	£
Clinical Negligence /Personal Injury (Receipt from WRP)	1	1	£11,000
Total	**1**	**1**	**£11,000**

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 16 open which are inclusive of clinical negligence (11),and personal injury (5) claims with NWSSP Legal and Risk Services instructed to act on behalf of the health board. The health board also have 5 potential claim files open which are currently being considered.

Redress (Putting Things Right)

These relate to smaller claims that are managed by the THB in line with the Putting things Right Legislation. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2022 to 31st October 2022 are included in **Appendix Aii.**

	No. of payments/receipts	No. of cases	£
Redress Payments	14	11	£46,055.80
Total	**14**	**11**	**£46,055.80**
Redress Receipts	7	7	£42,843.00
Total	**7**	**7**	**£42,843.00**

There are currently 14 open redress cases at variable stages:-

- 3 cases requiring expert opinion
- 4 cases requiring legal advice from L&RS
- 3 offers made to complainant
- 4 cases at various stages of review/progression

General Medical Practice Indemnity (GMPI)

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019. These are reimbursed to the THB in full but there is often a timing difference between years on reimbursements.

Details of the payments made during 1st April 2021 to 31st October 2022 are included in **Appendix Aiii.**

	No. of payments/receipts	No. of cases	£
GMPI Payments	0	0	£0
Total	**0**	**0**	**£0**
GMPI Receipts	1	1	£13,612.00
Total	**2**	**1**	**£612.00**

There are currently 4 open GMPI cases at variable stages of review/progression.

There has been one reimbursement from Welsh Risk Pool during 2022/23.

Other Special Payments

Details of the payments are included in Appendix Aiv.

	No. of payments/receipts	No. of cases	£
Other Special Payments	2	2	£344.40
Total	**2**	**2**	**£344.40**

Conclusion

The Audit Committee is asked to note the above interim report for 2022/23 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

Full details including supporting listing is attached at Appendix Ai – Aiv

Benchmarking

The Committee at a previous meeting asked for an update on how the THB performed in comparison to other NHS Wales bodies. The Welsh Risk pool undertakes Annual Review which outlines the caseload of claims and redress cases across NHS Wales. It provides some trend history and outlines the distribution of specialities associated with matters. The report for 2021/22 is attached at **Appendix Bi.**

In addition to the Annual Review report, the Welsh Risk Pool also provide a supplement which outlines the health body's data in comparison to the all-Wales position and this is included for information at **Appendix Bii.** Please note the cases quoted within this supplement include Ex-Health Authority related cases but there is no financial effect of these cases for Powys THB as they are totally funded by the Welsh Risk Pool.

NEXT STEPS:

The Audit Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

Losses And Special Payments for 2022-23 Financial Year
1st April 2022 to 31st October 2022

Appendix Ai

Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Claimant Costs	MN/030/1564/MN	Apr-22	£18,500.00	£18,500.00	Case Closed
Clinical Negligence	Interim Claimant Costs and Damages	MN/030/1441/AF	Apr-22	£22,500.00	£22,500.00	Case ongoing
Clinical Negligence	Damages	MN/030/1628/AR	May-22	£4,000.00		
Clinical Negligence	CRU Charges	MN/030/1628/AR	Jul-22	£678.00		
Clinical Negligence	Claimant Costs	MN/030/1628/AR	Aug-22	£14,500.00	£19,178.00	Case Closed
Clinical Negligence	Defence Costs	MN/030/1612/EC	Aug-22	£500.00	£500.00	Case ongoing
Personal Injury	Defence Costs	PI/030/1590/AH	Aug-22	£660.00	£660.00	Case ongoing
Personal Injury	Defence Costs	PI/030/1552/AH	May-22	£271.70	£271.70	Case Closed
Personal Injury	Defence Costs	PI/030/1669/RHJ	Jul-22	£254.10	£254.10	Case ongoing
		TOTAL		£61,863.80	£61,863.80	

Reimbursements from Welsh Risk Pool

Receipt Date	Laspar Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Apr-22	GMP7A7-0010/SD	Damages	-£11,000.00
		Total	£0.00

Appendix Aii

Losses And Special Payments for 2022-23 Financial Year
1st April 2022 to 31st October 2022

Appendix Ai

Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Claimant Costs	MN/030/1564/MN	Apr-22	£18,500.00	£18,500.00	Case Closed
Clinical Negligence	Interim Claimant Costs and Damages	MN/030/1441/AF	Apr-22	£22,500.00	£22,500.00	Case ongoing
Clinical Negligence	Damages	MN/030/1628/AR	May-22	£4,000.00		
Clinical Negligence	CRU Charges	MN/030/1628/AR	Jul-22	£678.00		
Clinical Negligence	Claimant Costs	MN/030/1628/AR	Aug-22	£14,500.00	£19,178.00	Case Closed
Clinical Negligence	Defence Costs	MN/030/1612/EC	Aug-22	£500.00	£500.00	Case ongoing
Personal Injury	Defence Costs	PI/030/1590/AH	Aug-22	£660.00	£660.00	Case ongoing
Personal Injury	Defence Costs	PI/030/1552/AH	May-22	£271.70	£271.70	Case Closed
Personal Injury	Defence Costs	PI/030/1669/RHJ	Jul-22	£254.10	£254.10	Case ongoing
		TOTAL		£61,863.80	£61,863.80	

Reimbursements from Welsh Risk Pool

Receipt Date	Laspar Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Apr-22	GMP7A7-0010/SD	Damages	-£11,000.00
		Total	£0.00

Appendix Aiii

Losses And Special Payments for 2022-23 Financial Year
1st April 2022 to 31st October 2022

Appendix Ai

Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Payment	Payments	Amount by case	Additional Information
Clinical Negligence	Claimant Costs	MN/030/1564/MN	Apr-22	£18,500.00	£18,500.00	Case Closed
Clinical Negligence	Interim Claimant Costs and Damages	MN/030/1441/AF	Apr-22	£22,500.00	£22,500.00	Case ongoing
Clinical Negligence	Damages	MN/030/1628/AR	May-22	£4,000.00		
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Clinical Negligence	Claimant Costs	MN/030/1628/AR	Aug-22	£14,500.00	£19,178.00	Case Closed
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Personal Injury	Defence Costs	PI/030/1552/AH	May-22	£271.70	£271.70	Case Closed
Personal Injury	Defence Costs	PI/030/1669/RHJ	Jul-22	£254.10	£254.10	Case ongoing
		TOTAL		£61,863.80	£61,863.80	

Reimbursements from Welsh Risk Pool

Receipt Date	Laspar Reference	Nature of Reimbursement From Welsh Risk Pool	Amount
Apr-22	GMP7A7-0010/SD	Damages	-£11,000.00
		Total	£0.00

Appendix Aiv

Other Losses And Special Payments for 2022-23 Financial Year
1st April 2022 to 31st October 2022

Appendix Aiv

Payment Date	Laspar Reference	Nature of Reimbursement	Amount
Jun-22	236C4EG0001	Replacement phone screen for patient. Damage accidently caused by staff member	£70.00
Aug-22	236C4EG0002	Replacement spectacles for member of staff. Damage caused by patient	£274.40
		Total	£344.40

Welsh Risk Pool Services and Legal & Risk Services

Annual Review 2021-2022

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Shared Services Partnership

Contents Page

Foreword

Members of the public in Wales are proud of, and thankful for, the services provided by their NHS and this was clearly evidenced by the gratitude and appreciation shown to the service and its staff during the pandemic.

During my career in the NHS, I have constantly been impressed with the dedication and expertise of the staff who work tirelessly to provide care and treatment when it is required and support our communities to improve their health and wellbeing. When compared to the number of patient contacts undertaken by NHS Wales each year, the number of times when problems occur, or things go wrong, is very small.

Professor Tracy Myhill OBE,
Chair of NHS Wales Shared Services Partnership

However, for every time something does go wrong and harm occurs, or systems fail, the NHS must have robust processes to learn lessons, improve processes and share best practice. The Welsh Risk Pool and Legal & Risk Services play a vital role in supporting health bodies to investigate what has happened, put preventative measures into place where possible and achieve a satisfactory resolution for any person affected.

It is widely recognised that all areas of the NHS across the UK are experiencing a high level of claims. This is seen in NHS Wales. Whilst it is pleasing to note that the number of claims is not increasing in NHS Wales we must recognise that the value of individual claims does increase year on year. Successful claims provide some recognition and recompense for patients and families, although unfortunately cannot change what has happened. On average, 45% of personal injury and clinical negligence claims are successfully defended.

Using an entirely in-house legal service to manage clinical negligence and personal injury claims in NHS Wales, our professional influence is also achieving considerable savings to the Welsh taxpayer. The wide experience of the in-house legal service, in all areas of law affecting modern health bodies, provides rapid and effective advice to leaders throughout the NHS.

The Safety & Learning programme operated by the Welsh Risk Pool involves investing some of the money which would otherwise be spent on claims to achieve reductions in incidents and thus lead to improved services with fewer claims. The programmes are well respected amongst clinical teams in Wales and are having a genuine impact.

The most frequently occurring specialty for claims is in maternity services and it is vital we support health bodies to learn and improve from what has gone wrong in these cases. We have introduced the PROMPT Wales and Community PROMPT Wales programme and this important initiative was recognised when its lead, Midwife Sarah Hookes, was awarded the Wales RCM Midwife of the Year accolade.

The introduction of the Putting Things Right regulations in Wales ten years ago has provided a system for the smooth and effective resolution of concerns raised by patients and their relatives whilst reducing the burden of legal costs on the NHS. With the responsibility for reimbursing expenditure for redress cases now placed with the Welsh Risk Pool, the team is able to provide a fuller picture of the causal factors and lessons learned which arise from redress cases as well as claims and continue to work with local clinical teams to identify areas for improvement.

The General Medical Practice Indemnity Scheme, operated by Legal & Risk Services, was introduced in 2019. This team works closely with primary care services to help with investigations and reduce the potential for litigation in this area. This scheme introduces national scrutiny of lessons learned within the primary care sector for the first time.

I am very proud of the work done by the Welsh Risk Pool and Legal & Risk Services working with colleagues across the NHS in Wales. The purpose of this report is to outline the current position and forecast for claims and redress cases and to outline the incredible work that the team does every day.

My senior team will be working with every Board in NHS Wales to maximise learning and to improve quality and safety, using the data related to each individual health body to the maximum possible.

About Tracy Myhill

Tracy was appointed Chair of NWSSP in 2021 having previously retired from the NHS following a career that spanned 37 years. Beginning her career as a receptionist in Cardiff's Dental Hospital, Tracy progressed into the human resources sector and held roles at local and national level. She has previously worked as Chief Executive of the Welsh Ambulance Service NHS Trust and of Swansea Bay University Health Board.

Our Services

The Welsh Risk Pool is a mutual body which supports all health organisations in NHS Wales by administering the risk pooling scheme, which provides the means by which all Health Boards, Trusts and Special Health Authorities in Wales are able to indemnify against risk.

The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve. The team works with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient and staff safety and clinical outcomes.

Legal & Risk Services provide legal advice and representation for all health bodies in Wales. With specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, the Legal & Risk teams are able to support organisations in providing safe and efficient health and care services to the population of Wales.

Welsh Risk Pool

Reimbursement
We reimburse losses and special payments incurred by health bodies in accordance with the WRP Reimbursement Procedures.

Consent
We coordinate the all-Wales approach to Consent to Examination & Treatment, provide a national training solution for clinicians involved in the consent process and procure a library of approved consent information leaflets to support clinicians in ensuring patients can give informed consent.

Once for Wales Concerns Management System
We lead the design, implementation and use of the Once for Wales Concerns Management System, which provides consistency in the platform for capturing, investigating and reporting on all concerns in health bodies and primary care.

Concerns Management Training
We provide training to claims managers, redress case managers and staff involved in coordinating inquest cases.

Safety & Learning
We scrutinise the learning from events relating to claims and redress cases. We coordinate a national learning advisory panel to consider and share best practice and lessons learned from cases.

PROMPT Wales
We coordinate the all-Wales approach to PROMPT Wales and Community PROMPT Wales, which delivers obstetric emergency training to midwives, obstetric doctors and anaesthetists involved in maternity care.

Specialist Investigation Support
Using the vast clinical experience across NHS Wales, we support health bodies with complex and organisational investigations where the independence of the WRP can add value.

Legal & Risk Services

General Medical Practice Indemnity
A team of highly skilled solicitors with a particular focus and expertise in managing clinical negligence claims arising from primary care practice.

Clinical Negligence
A department of in-house solicitors and legal support staff who manage the clinical negligence caseload across all health bodies. We aim to handle claims proactively, fairly and consistently.

Employment
A team of solicitors and legal executives advising on high level strategic policy matters, case management and tribunal hearings.

General Healthcare Advice

A wide spectrum of issues can be faced by health bodies and clients. This team draw from the diverse experience within Legal & Risk Services to provide timely advice.

Inquests
Our inquests team offer full support to our clients, from initial investigations through inquest hearings and beyond.

Commercial, Regulatory and Procurement
A team of highly specialised lawyers who support health bodies in managing these issues in a practical and timely manner.

Complex Patient (Court of Protection)
A team of very experienced healthcare lawyers who provide rapid advice to ensure NHS staff are able to comply with legal requirements and deal with complex legal issues regarding the provision of care and treatment.

Personal Injury
This team have intimate knowledge of the NHS enabling swift and efficient advice on managing claims and providing expert advice on reduce risks in the workplace.

Property acquisitions, disposals and leases
This highly specialised team work closely with Specialist Estates Services to support all health bodies on matters relating to the NHS Wales estate.

Putting Things Right
We offer a flexible and hands-on approach to health bodies in dealing with matters under the PTR regulations.

Our People

Mark Harris

Mark Harris is the Director of Legal & Risk Services and the Welsh Risk Pool. Mark has an LLB law degree, an LLM Master's degree in Commercial Law/Marine Affairs and a Postgraduate Certificate in Health Service Management.

Having worked in Legal & Risk for over two decades, Mark has vast experience of working on clinical negligence and general advisory matters and was a Team Manager and the Deputy Director of the service prior to being appointed as the Director.

Mark's areas of special interest are clinical negligence claims, health funding disputes and governance. Mark has provided legal advice on a very wide range of one-off legal conundrums that face NHS bodies in their day-to-day business, having advised on a multiplicity of individual legal issues in the last decade. Mark led Legal and Risk Services' engagement with Welsh Government to implement the GP indemnity scheme which commenced in 2019.

Daniela Mahapatra

Daniela Mahapatra is the Deputy Director of Legal & Risk Services. Daniela qualified as a Solicitor in 2005. She obtained her LLB Law degree at the University of Wales, Swansea, before moving to Cardiff to undertake the Legal Practice Course. Practicing in employment law, Daniela advises all health bodies in Wales in complex employment cases.

Daniela is a member of the HPMA Wales Committee, arranging various training events for the NHS Wales HR workforce (Workforce & OD).

In May 2016, Daniela was elected as the Wales representative for the Employment Lawyers Association. As part of this role, Daniela assisted with the roll out of the Employment Tribunal Litigants in Person Support Scheme (ELIPS) in the Wales Employment Tribunal, which provides free assistance to unrepresented litigants (claimants and respondents) at the Employment Tribunal.

Daniela has taught the Employment Law module on the HRM course at the University of South Wales. Daniela is also a mentor as part of the Coleg Y Cymoedd mentoring scheme.

Sarah Watt

Sarah Watt is the Head of Healthcare Litigation, the strategic lead for clinical negligence claims, Putting Things Right and Public Inquiry work. Sarah has a LLB Law Degree, Law Society Finals Examination pass and Level 5 Qualification from the Institute of Leadership and Management.

Sarah joined Legal & Risk Services in 2003 after working for leading UK healthcare law firms. She became a Team Leader in 2005 and was appointed Head of Healthcare Litigation in 2021.

Sarah is particularly experienced in high profile investigations, very high value claims and is leading the work to support health bodies giving evidence to the coronavirus public inquiry.

Jonathan Webb

Jonathan Webb is the Head of Safety & Learning and is the operational lead for the Welsh Risk Pool. Jonathan is a Registered Paramedic, an experienced Clinical Mentor and has worked in the NHS since 1990. Having completed a degree in Education at Wolverhampton University and studied Management at University of Reading Henley Business School, Jonathan has completed a Master's degree in Occupational Health & Safety at Loughborough University.

Prior to joining Legal & Risk Services in 2016, Jonathan was Head of Risk Management in an English Acute Trust where he developed an investigation training programme for clinical leaders. He has previously held a similar role in the Channel Islands, where he was responsible for coordinating a States-Wide Risk Register & Assurance Programme. Jonathan's role focusses on scrutinising and sharing lessons learned from claims and redress cases, delivering bespoke programmes to address areas of litigation, leading the Once for Wales Concerns Management System and coordinating assessments of health bodies' systems for handling concerns.

Sue Saunders

Sue Saunders is the Head of Finance for Welsh Risk Pool. The financial functions of the Welsh Risk Pool and Legal & Risk Services are coordinated by the Corporate Finance Team within NHS Wales Shared Services Partnership. Sue is responsible for the Welsh Risk Pool and Legal & Risk accounts. Chairing the sub-Technical Accounting Group for Welsh Risk Pool matters, Sue ensures that the application of financial principles is consistent throughout NHS Wales.

A qualified accountant, Sue has many years of experience in NHS accounting and supports health bodies with their financial returns relating to the Welsh Risk Pool to Welsh Government.

Our people are our biggest asset in the Welsh Risk Pool and Legal & Risk Service.

With over 125 whole time equivalent solicitors, chartered legal executives, pre-qualified lawyers and support staff, the Legal & Risk service is able to support all health bodies in NHS Wales in all areas of law.

With twelve whole time equivalent established staff and a flexible workforce of bank and seconded colleagues, the Welsh Risk Pool is able to draw on clinical and operational experience from across NHS Wales to deliver its services.

Welsh Risk Pool Committee

Decisions in relation to the rimbursement procedures, workplans for reviews and the reimbursment of claims & redress cases are taken by a national committee drawn from executive and associate roles from Health Bodies and Welsh Government. Members represent their roles and peers across Wales rather than their individual organisation.

Acting as a sub-committee of the Shared Services Partnership Committee, the Welsh Risk Pool Committee ensures consistency in decisions and effective scrutiny of this complex sector.

Our Caseload

The majority of people who receive care from NHS Wales receive an excellent service that is provided by a dedicated and well-trained workforce. Whilst NHS Wales should be justifiably proud of its achievements, there is no room for complacency and occasionally mistakes happen or processes and systems fail, which can lead to claims being paid to patients or staff affected or expenditure on redress.

In addition to the harm experienced by those involved in events which lead to litigation, every penny spent on claims and redress cases cannot be spent on providing health and care in NHS Wales.

The Welsh Risk Pool and Legal & Risk Services will continue to work carefully with each party in every matter to achieve the right resolution in the case and a fair outcome for all parties.

Through the process of learning from events, causal factors that have led to a claim or redress case are identified and learning or improvements put into place to reduce the potential for repeat events.

Claims & Redress Case Profile

The profile of cases managed by the Welsh Risk Pool and Legal & Risk Services relate to clinical negligence, personal injury and redress matters.

The Welsh Risk Pool administers the risk pooling arrangement and meets the cost of financial losses for claims over £25,000 and all reimbursable expenditure on redress cases. The most significant element of expenditure relates to clinical negligence matters.

Clinical negligence and personal injury claims are managed using the legal processes outlined in the pre-action protocols and legal procedures issued by the courts of England & Wales. If a claim proceeds to court, the conduct of the claim is coordinated by a judge.

Redress cases are conducted using the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which are known as the Putting Things Right Regulations, and these have a published legal guidance which sets out the expectations of parties.

Clinical Negligence Matters

The number of substantive open clinical negligence cases at the end of each financial year provides a useful indicator of the current clinical negligence caseload pressure experienced by NHS Wales. This data for the last ten years is shown in Fig1. These figures do not include cases from the Scheme for General Medical Practice Indemnity, which are managed separately.

Some cases remain open for a considerable period of time, as matters are analysed and financial values determined. Some more complex cases can remain open for over ten years.

There was a spike in cases as we approached 2013 because of a rush by Claimant's solicitors to open new cases before conditional fee agreements were abolished by a change in the law.

We also changed our methodology for opening new cases from 2017/18 - only accepting those with a letter of claim or that fell into the criteria for our early reporting scheme, where we require health bodies to inform us of specific incidents as they occur. Prior to that we accepted matters even if there was not yet a letter of claim, such as pre-action disclosure requests. We have done our best to exclude these essentially non-substantive matters within the numbers shown in Fig1. However, the way the data is held presents some challenges to easy to identify these matters. Therefore, there is a chance that some remain included in the data prior to 2017/18.

Due to the duration of some cases remaining open, the spike in cases around 2013 and the change in methodology of accepting cases in 2017, it is not possible to identify an overall determinable trend in case numbers. There is, however, an increase in the complexity and value of cases, with a consequential financial impact to NHS Wales.

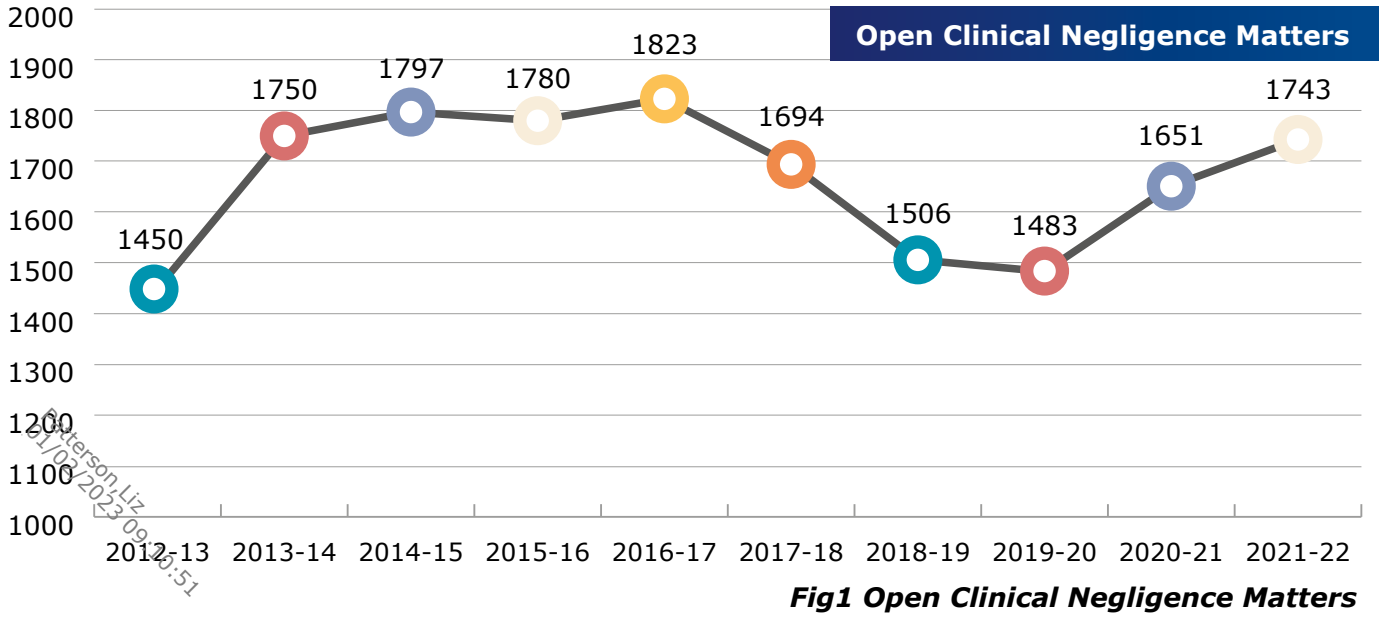


Fig1 Open Clinical Negligence Matters

On behalf of NHS Wales, Legal & Risk Services carefully investigates all matters brought against health bodies and is successful in defending cases where this is possible, which reduces avoidable costs for the Welsh taxpayer.

Fig 2 provides a summary of the number of cases closed without damages over the last three years. This shows that we are consistently defending approximately 45% of cases.

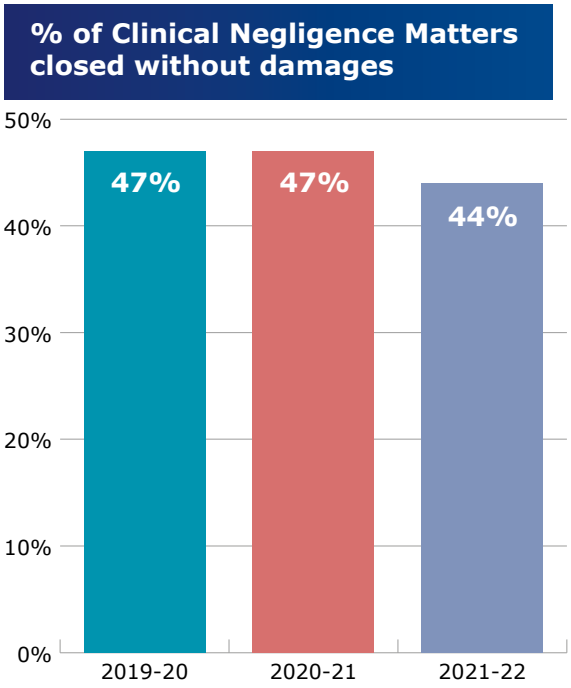


Fig2 Percentage of Clinical Negligence Matters closed without damages paid

NHS Wales undertakes a wide range of clinical procedures and provides care and treatment in a wide array of clinical settings. Claims may arise from any clinical contact and the Welsh Risk Pool monitors the distribution of the principal clinical specialties identified in a claim.

The most frequently occurring specialty relating to clinical negligence claims is maternity services, which includes obstetrics and midwifery-led services. These represent 17.73% of all clinical negligence cases being managed by Legal & Risk Services during 2021/22. The Welsh Risk Pool has invested significantly to work with clinical teams in maternity services across NHS Wales to address the causal factors for claims.

Matters relating to the assessment, treatment and surgery, in orthopaedic and trauma cases represent 13.51% of all clinical negligence cases being managed by Legal & Risk Services during 2021/22. These matters include the wide range of orthopaedic procedures which are conducted by NHS Wales.

Many patients present to emergency departments, specialist assessment units and minor injury services and claims related to these settings represent 11.60% of all clinical negligence matters being managed by Legal & Risk Services during 2021/22.

The list of specialities captured by the Welsh Risk Pool and Legal & Risk systems relate to a bespoke list that was first utilised in approximately 2000. With the introduction of a new electronic Case Management System over the next few years, it is anticipated that the speciality data will be published in future using the national NHS Wales list as far as possible and that this will help organisations to extrapolate and use data from a range of performance and quality management sources.

Fig3 outlines the distribution of the top ten clinical specialties in clinical negligence and Table1 provides a breakdown of all clinical specialities.

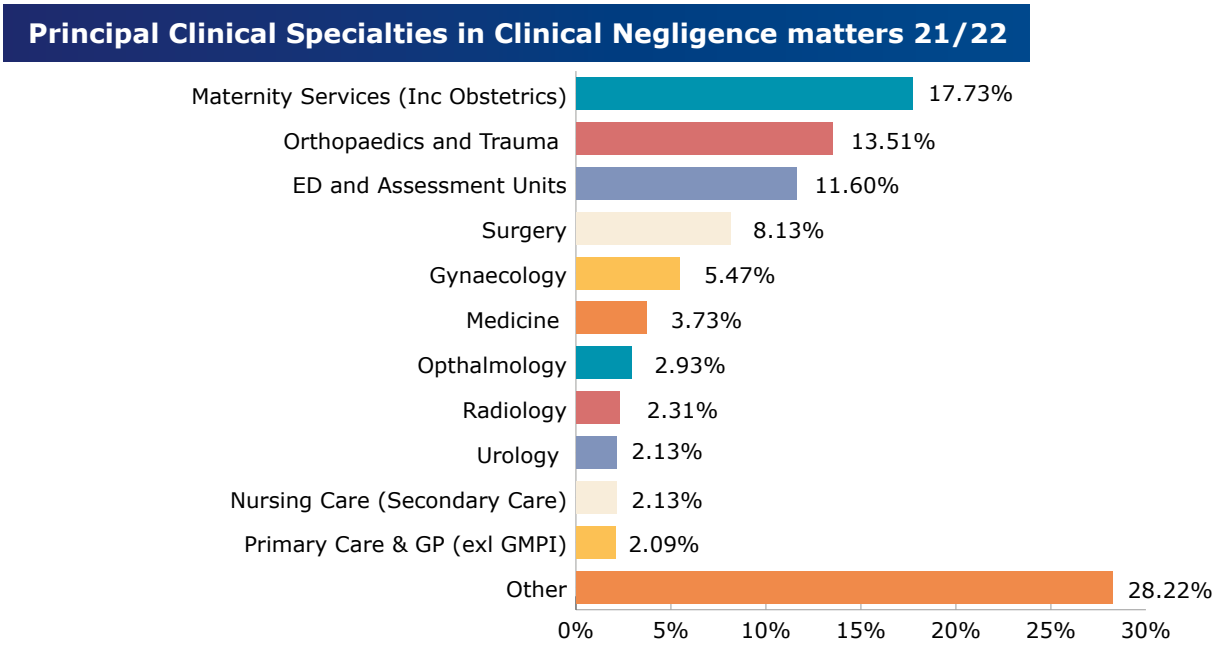


Fig3 Breakdown of Principal Clinical Specialties in Clinical Negligence matters

Principal Specialty in Clinical Negligence matters	%	Principal Specialty in Clinical Negligence matters	%
Admin, Estates & Business Services	*0.13%*	Mental Health & Psychology	*2.31%*
Ambulance / Paramedics	*1.24%*	Nephrology	*0.49%*
Anaesthetics	*0.80%*	Neurology	*1.07%*
Audiology	*0.04%*	Neurosurgery	*1.11%*
Cardiology	*1.42%*	Nursing Care (Secondary Care)	*2.13%*
Cardiothoracic Surgery	*0.36%*	Oncology	*1.42%*
Colorectal Surgery	*0.76%*	Ophthalmology	*2.93%*
Cytology	*0.31%*	Oral & Maxillofacial Surgery	*0.44%*
Dental	*0.49%*	Orthopaedics & Trauma	*13.51%*
Dermatology	*0.53%*	Paediatrics	*2.84%*
District Nursing & Health Visiting	*0.36%*	Pathology, Histology & Microbiology	*0.40%*
Ear Nose & Throat	*1.51%*	Physiotherapy	*0.53%*
Emergency Dept & Assessment Units	*11.60%*	Plastic Surgery	*0.13%*
Gastroenterology	*1.16%*	Podiatry	*0.18%*
Genetics	*0.09%*	Primary Care (excl GMPI)	*2.09%*
Genitourinary Medicine	*0.13%*	Radiology	*2.31%*
Geriatric Medicine	*0.44%*	Respiratory	*0.36%*
GP Out of Hours	*0.36%*	Rheumatology	*0.27%*
Gynaecology	*5.47%*	Speech Therapy	*0.04%*
Haematology	*0.53%*	Surgery	*8.13%*
Maternity Services	*17.73%*	Urology	*2.13%*
Maxillofacial	0.44%	OTHER / UNSPECIFIED	5.51%
Medicine	3.73%		

Table1 Summary of Principal Specialties in Clinical Negligence matters

Personal Injury Cases

In addition to claims for alleged clinical negligence, the Welsh Risk Pool and Legal & Risk Service also deal with matters of public liability, occupier's and employer's liability brought against NHS Wales health bodies. These can be complex matters involving the gathering of evidence relating to operational issues, health & safety compliance and risk assessments.

At the end of 2021/22 there were 470 open personal injury matters against NHS Wales and there is an upward trend in personal injury matters since 2005. There was a peak in new personal injury matters opening in early 2013 caused by the approach of fixed recoverable costs and a change to the law which limited the grounds on which personal injury claims could be brought.

Fig 4 shows the number of open personal injury matters since 2005. We are reliably able to report this far back because historically we have only opened personal injury claims on receipt of a letter of claim.

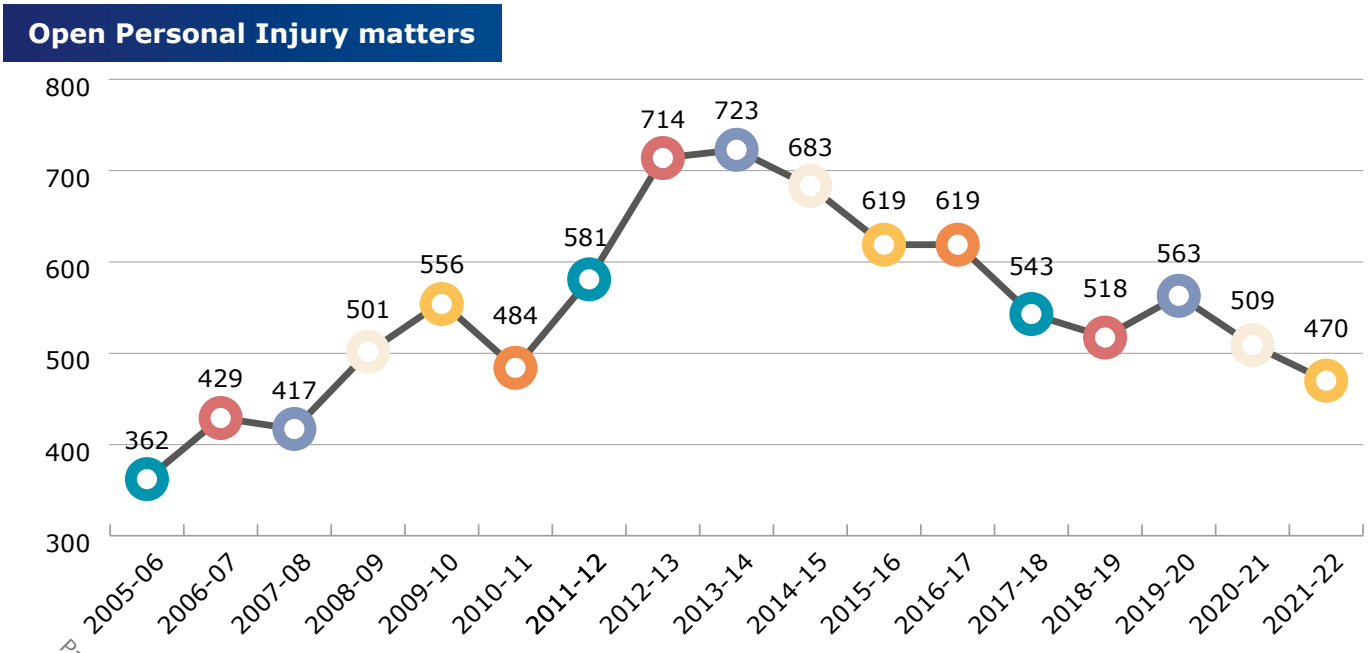


Fig4 Open Personal Injury matters

The Legal & Risk Services team work closely with managers within health bodies to defend cases where this is possible, reducing the burden of legal costs to organisations. NHS Wales has successfully defended over 45% of personal injury cases. Fig 5 shows the continuing positive trend in successfully defended personal injury claims.

EXAMPLE CASE – claim successfully defended at trial

A claim was brought by a former employee of an organisation which provides services to all health bodies in NHS Wales, stating that they had injured their knee due to poor parking and access arrangements at the hospital they were deployed to. The claim was strenuously defended and proceeded to trial in January 2022.

The Judge found that the employing organisation and the hospital had reasonable measures in place, the former employee had received sufficient training and there were suitable arrangements for escalating issues. The claim therefore failed, and no damages were awarded.

Fig 5 shows a gradual increase in successfully defended personal injury claims.

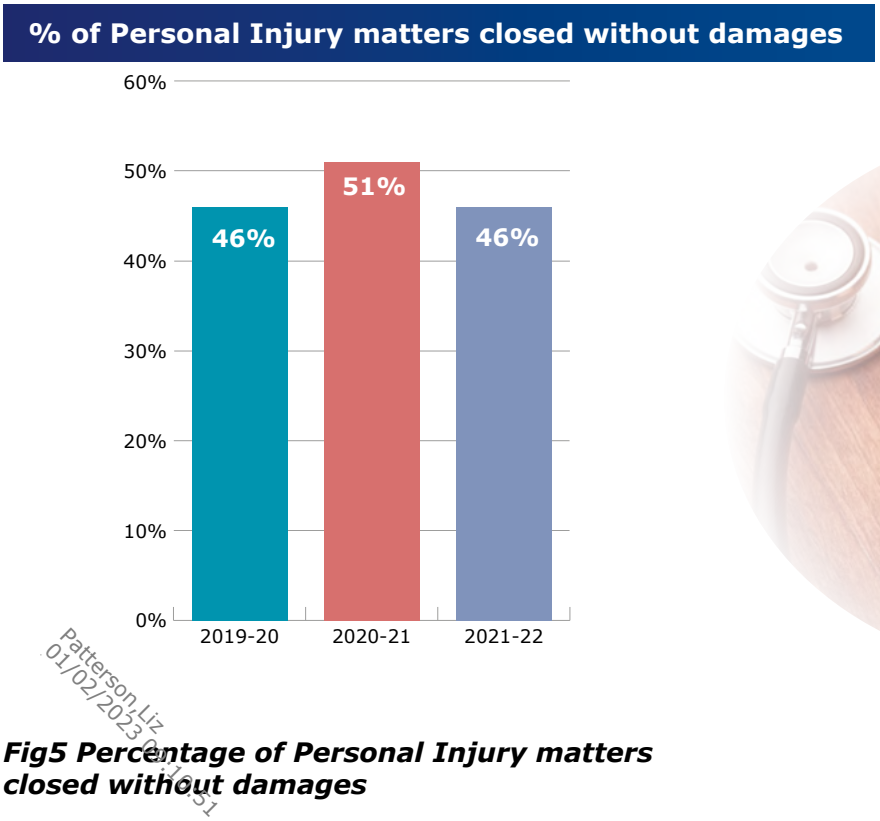


Fig5 Percentage of Personal Injury matters closed without damages

Redress Cases

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 places duties on health bodies to consider payment of appropriate redress in matters where there is a qualifying liability. The Regulations require health bodies to consider redress in circumstances where harm is alleged and the likely value of any claim would not exceed £25,000 in damages. Dealing with these cases in this way has a significant impact in reducing the legal costs associated with claims brought in the traditional way and provides an effective resolution for those affected and achieves significant savings for the NHS.

Cases that may lead to consideration of redress include incidents reported by staff within organisations and complaints received from service users or their representatives. Health bodies are required to investigate matters and to determine whether there is a qualifying liability.

Since 2018, the Welsh Risk Pool has been allocated responsibility for the scrutiny of learning and reimbursement of expenditure incurred by health bodies in relation to redress cases.

Redress cases are managed locally by specialist teams within health bodies. The Legal & Risk Service has a specialist team which advises and supports organisations in relation to redress matters. Formal reviews by the Legal & Risk team are required in all cases where a proposed damages payment exceeds £25k, where payments to the UK Government Compensation Recovery Unit exceeds £3k and in all cases where qualifying liability is considered to have been met in a matter relating to the coronavirus pandemic.

From 2019, health bodies have been required to provide information on their current caseloads to assist with planning and budgeting. This provides an insight into the progress of matters across NHS Wales.

In 2021/22, a total of 924 redress cases were being managed by health bodies in NHS Wales. This represents a 6% reduction in the overall caseload and follows a small reduction in 2020/21.

The reduction that has been seen can be attributed to a reduction in incident and complaint investigations during the pandemic and it is expected that 2022/23 will see a sharp increase in the caseload.

Fig6 outlines the redress caseload over the last three years.

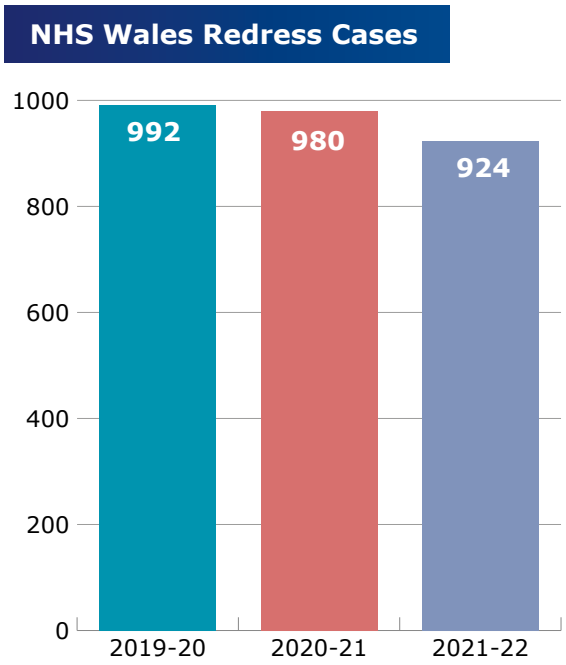


Fig6 Redress Cases for last 3 years

Considering the clinical speciality to which a redress case relates is a useful indicator of themes and trends.

Traditionally, each health body has considered redress cases in relation to its own list of specialties which do not align to provide a national picture. With all organisations now utilising the Once for Wales Concerns Management System to capture and manage redress cases, it is anticipated that a national picture will be available from 2022/23.

From case analysis, the most commonly occurring specialities within redress cases are Emergency Department, Orthopaedics, and General Surgery.

Periodical Payment Orders

In the vast majority of personal injury and clinical negligence matters, settlement as damages is made in the form of an immediate payment of a lump sum directly to the claimant.

In matters in which the court is making an award relating to future pecuniary loss, it may order that the damages take the form, whether wholly or partly, of periodical payments. The Damages Act 1996 empowers the court in personal injury & clinical negligence proceedings to make a periodical payments order, a lump sum award or a combination of the two.

Periodical Payment Orders are generally seen in cases where a payment is needed to provide care and support for a claimant over a sustained period of time.

The payments are index-linked, rising by an agreed inflation measure each year to ensure that the claimant receives an appropriate sum to meet their needs.

The Welsh Risk Pool administers all Periodical Payment Orders for NHS Wales health bodies. At the end of 2021/22, there were a total of 141 active Periodical Payment Orders (PPOs). Seven PPO arrangements have been agreed in cases which settled recently, but which the payment has not yet started. PPO payments made in 2021/22 totalled £16.644m.

With the growth in inflation and increasing numbers of active PPOs, the value of PPOs have increased by £5,775m in the last five years. This represents a 53% increase in payment costs with a 27% increase in active cases from 111 in 2017/18. This is outlined in Fig7.

Periodical Payments over last five years

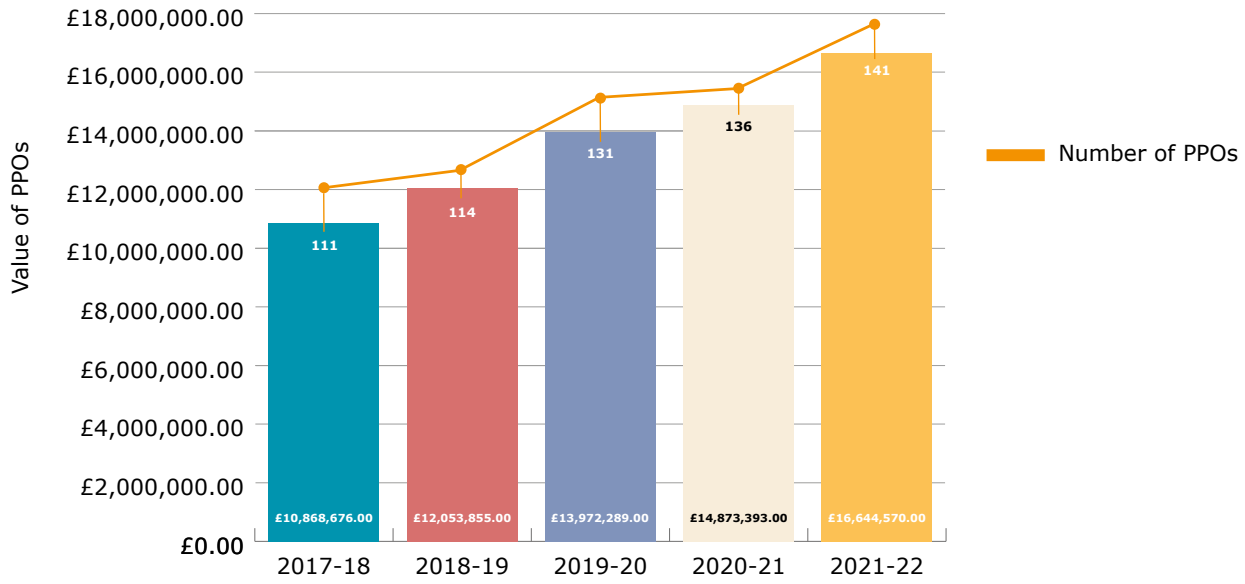


Fig7 Value & Number of PPOs over last five years

Legacy matters from Former Health Authorities

The Welsh Risk Pool manages claims brought against former Health Authorities in NHS Wales. These legacy organisations were replaced with a number of NHS Trusts across Wales between 1993 and 1996 and these new organisations did not inherit the liabilities of the predecessor organisations. Where a claim arises, these matters are managed by the Welsh Risk Pool and are conducted on behalf of Welsh Government, in the name of Powys Teaching Health Board through a Service Level Agreement.

As time progresses, the number of open matters continues to steadily decline. Whilst legal limitation may prevent a number of claims being brought successfully, some areas of claim cannot rely on limitation.

The most common claim now being brought against former Health Authorities relates to alleged exposure to asbestos between the 1960's and 1980's leading to a diagnosis of mesothelioma. These claims can be very challenging to investigate and personnel and potential evidence may simply not exist.

At the end of the 2021/22 period there were 25 open matters involving claims against former Health Authorities. Fig8 provides a breakdown of the number and types of these matters.

Former Health Authority Matters 2021/22

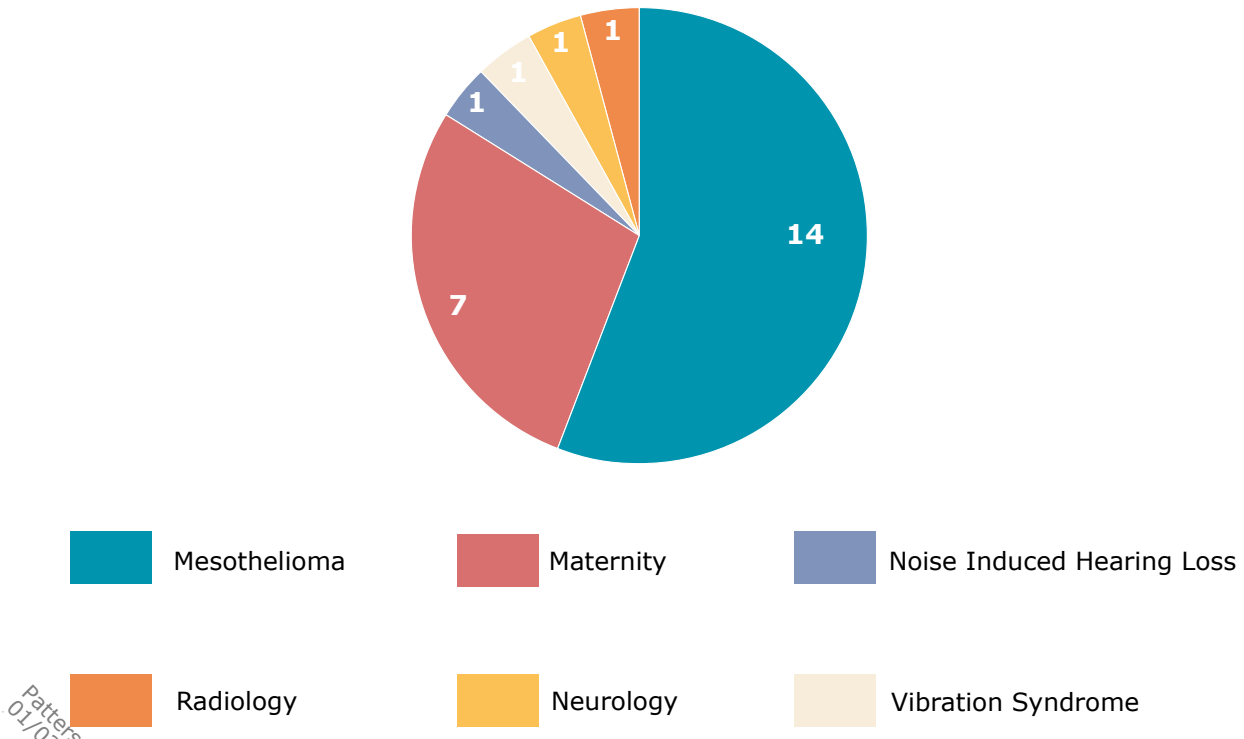


Fig8 Current Former Health Authority Matters 2021/22

Financial Planning & Performance

The Welsh Risk Pool receives two funding streams:

- Departmental Expenditure Limit (DEL) is used to meet the in-year costs associated with settled claims & redress cases. The DEL is funded by a core allocation provided by Welsh Government that is sourced from the annual healthcare budget. This is augmented with additional expenditure provided by Welsh Government and a risk sharing agreement that involves contributions from each health body using a formula depending on the size, claims experience and risk management standards of an organisation.

- Annually Managed Expenditure (AME) to meet the cost of accounting for the long term liabilities of claims.

The NHS Shared Services Partnership Corporate Finance Team, led by Director of Finance & Corporate Services Andy Butler, provides oversight and guidance on the management of the Welsh Risk Pool Budget.

Analysis of the current budget and use of financial forecasting tools enables the Welsh Risk Pool to confidently plan for settlement of case in-year and prepare for the likely financial requirements in the ensuing years.

2021/22 Budget Position

The Welsh Government core allocation for the year in 2021/22 was £107m for clinical negligence and personal injury claims and a £1.259m allocation for redress cases. Additional funding was provided by Welsh Government to support case progression. The funding is further supported by the risk sharing agreement which makes up the remainder.

The DEL funding for 2021/22 is outlined in Table2.

WRP DEL funding 2021/22	£m
Welsh Government Core	*107.000*
NHS Wales Risk Sharing Agreement	*16.495*
Welsh Government Additional Funding	*4.861*
Welsh Government Redress	*1.259*
Total Funding	**129.615**

Table2 WRP DEL funding 2021/22

The redress outturn for 2021/22 was £1.679 compared to the Welsh Government core allocation for this sector of £1.259m. Overspending on redress cases is recognised to have a beneficial effect on reducing the number of claims which are brought. The £420k overspend on redress was charged to the overall DEL expenditure and funded via the additional funding streams in-year.

The value of £16.495m risk sharing agreement contribution had been notified to health bodies during the budget planning phase and remained unchanged during funding reviews of the year. This enables health bodies to plan more confidently for their available expenditure.

Expenditure on DEL is a useful indicator to identify the current position and can be tracked to previous years. The expenditure within the DEL budget for 2021/22 compared with 2020/21 can be further analysed as shown in Table3.

WRP DEL Expenditure	2020/21 £m	2021/22 £m
Claims reimbursed & WRP Managed Expenditure	72.255	99.922
Redress Reimbursements	1.479	1.909
Periodical Payments	14.873	16.644
Safety & Learning Programmes	0.22	0.288
Clinical Negligence Team Funding	0.205	0.55
Movement on Claims Creditor	34.806	10.302
2021/22 expenditure	**123.838**	**129.615**

Table3 WRP DEL expenditure 2021/22

The creditor movement is an indicator that shows payments that have been made by health bodies which are not yet subject to reimbursement by the Welsh Risk Pool. The creditor movement has increased since the beginning of the financial year. This increase is partly related to the timing of settlements, a number of which were heavily profiled to the latter part of 2021/22.

Health bodies have therefore not had an opportunity to complete the learning review process and submit returns in order to receive reimbursements for these cases. Cases where approval of the learning plans have been deferred by the Welsh Risk Pool also account for an increase in the creditor movement.

Looking Forward – the Forecast

When considering the funds needed for future years, the Welsh Risk Pool and Legal & Risk Services categorise all claims and matters by allocating a rating depending on the likelihood of the case settling. The categories include, Remote, Possible, Probable and Certain and these are outlined in Table4.

Assessment of probability of settlement	
0% - 5%	Remote
6% - 49%	Possible
50% - 94%	Probable
95% - 100%	Certain

Table4 Breakdown of probably of settlement

For budget planning purposes, Probable and Certain cases are included in the forecast. The core DEL funding for the Welsh Risk Pool for 2022/23 is £109.435m which is a result of the pooling of the claims and redress allocations and an uplift of £1m for redress cases.

Planning and forecasting for the Welsh Risk Pool is included in the NHS Wales Shared Services Partnership Integrated Medium Term Plan (IMTP).

The current forecast for 2022/23 shows a resource requirement of £134.780m and the shortfall will be achieved through the application of the risk sharing agreement. Table5 provides a breakdown of the DEL forecast for the next three years.

3 Year Forecast	2022/23 £134.780M	2023/24 £136.138M	2024/25 £137.505M
Core WG Allocation	£109.435M	£109.435M	£109.435M
Risk Sharing Agreement 2022/23 to 2024/25 (Core Claims Growth)	£25.345M	£26.703M	£28.070M
Total DEL Forecast	***£134.780M***	***£136.138M***	***£137.505M***

Table5 Breakdown of DEL forecast for next three years

In 2021/22, the provisions have risen to £1.429bn which is an increase of £296.254m when compared to 2020/21. The provisions in 2020/21 experience a small decrease of £960k when compared to 2019/20 and this can be attributed to the impact of the first phase of the coronavirus pandemic. A profile of the provisions over the last three years is shown in Fig9 and a breakdown of the provisions is shown at Table6.

It is important to note that the significant increase in provision values does not relate to increased case numbers. The increase is primarily caused by the application of financial adjustments for inflation and the discounting of liabilities to net present value.

Provisions for future claims over the last 3 years

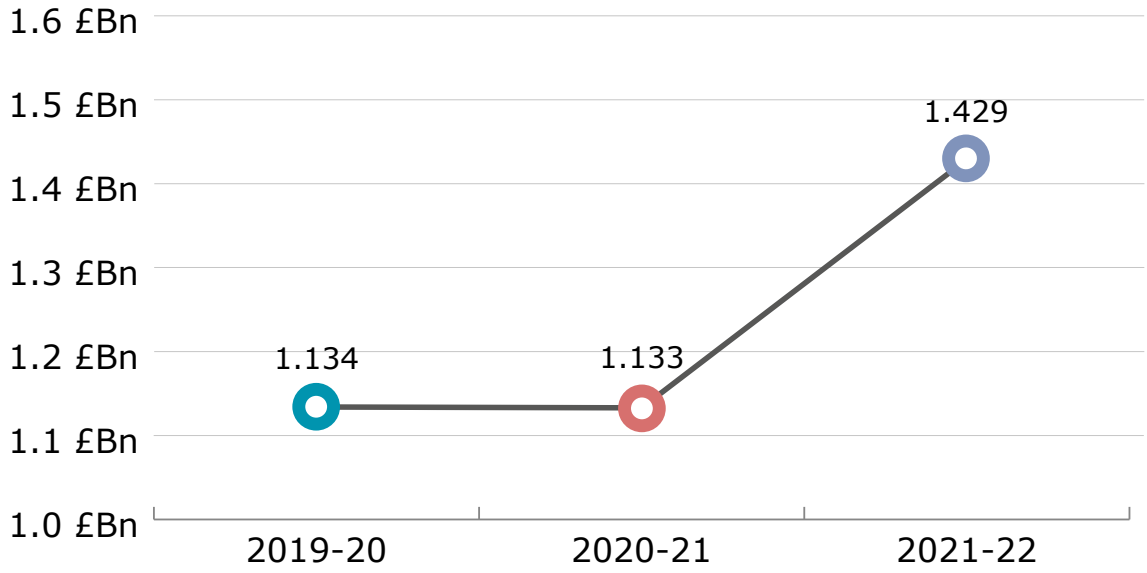


Fig9 WRP Provisions for last three years

Welsh Risk Pool Provisions	2019/20 £Bn	2020/21 £Bn	2021/22 £Bn
Probable & Certain Clinical Negligence Cases	0.676	0.646	0.781
Probable & Certain Personal Injury Cases	0.005	0.008	0.004
Probable & Certain Redress Cases	0.003	0.003	0.002
Defence Legal Fees and Others	0.009	0.009	0.009
Periodical Payment Orders	0.441	0.468	0.632
Total Provisions	**1.134**	**1.133**	**1.429**

Table6 Breakdown of WRP provisions

Risk Sharing Agreement

To support the in-year resource requirements, the Welsh Risk Pool requires contributions from its member health bodies to supplement the core allocation provided by Welsh Government.

The Risk Sharing Agreement provides a formulaic approach to calculating the required contributions and considers the size, claims experience and effectiveness of learning for each organisation.

Each of the five measures are outlined in Table7.

	Measure	Detail	Weighting
A	**HSCS and Prescribing Allocation**	Current measure	**30%**
B	**Claims History**	Last 3 years – rolling basis	**20%**
C	**New Claims transferred from the Service to LARS:** Number of New Cases < £25k	Last 12 months	**10%**
D	**Claims potentially affecting next years' spend:** 1. Cases with cash flows < 1 yr 2. PPO Allocation Utilisation	From CN database: 15% Actual Costs: 10%	**25%**
E	**Management of Concerns and Learning from Events** 1. Management of Concerns 2. Learning from Events	Annual WRP Inspections: 7.5% 7.5%	**15%**

Table7 Risk Sharing Agreement Measures

The first measure relates to the Health & Social Care Services Allocation (HSCS) and Prescribing Allocation allocated to an organisation by Welsh Government. This is major indicator of the size and complexity of an organisation.

The claims history considers the last three years and is calculated from the records of cases submitted for reimbursement and includes claims settled.

Measure C, cases under £25k, considers matters which could have been resolved through the redress case management system. The data for this is drawn from the Legal & Risk matter database.

The risk sharing calculation then considers claims that are likely to affect the next year's expenditure, considering each organisations profile of claims with cash flows, where payments are expected, within the next twelve months. This measure also considers the utilisation of PPOs which is taken from the forecast projections.

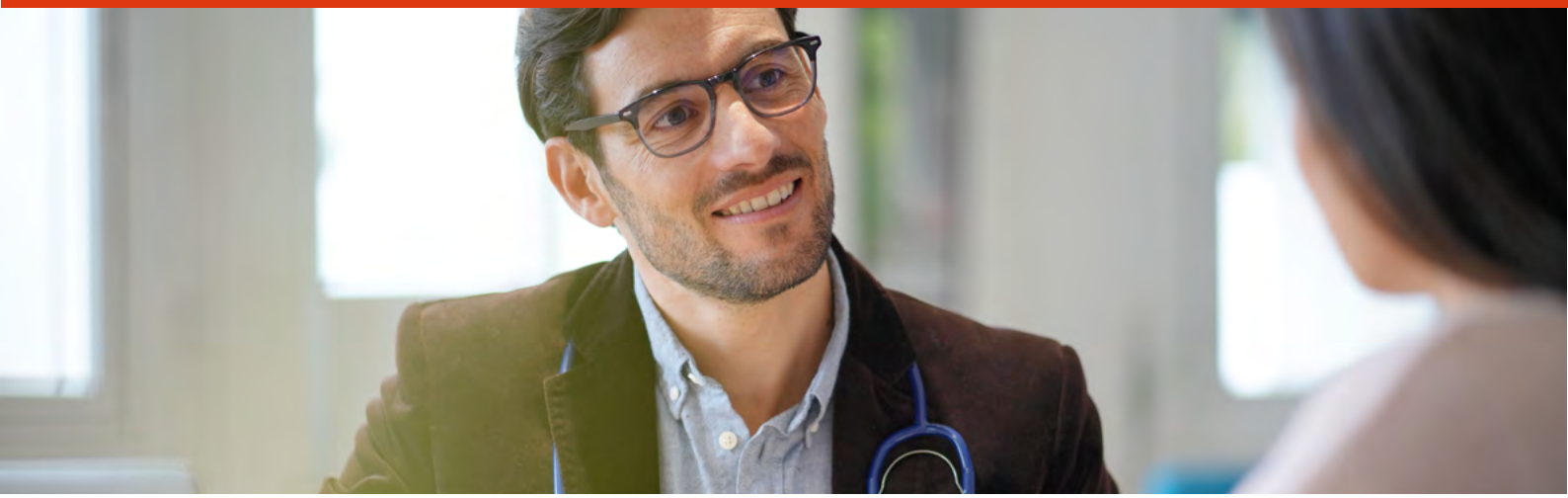
The final, and arguably most influential, measure is the Management of Concerns and Learning from Events. Each year the Welsh Risk Pool undertakes inspections of the processes and arrangements in each health body. The Welsh Risk Pool considers whether health bodies have complied with the WRP Reimbursement Procedures, the Once for Wales Concerns Management System and the guidance for the Putting Things Right legislation. The inspection programme was paused due to the pandemic and will recommence in the autumn of 2022/23.

Each organisation receives an individual contribution value which is a percentage of the total contributions required.

The Risk Sharing Agreement

- Weights the various measure in order to provide a balanced and equitable system
- Is transparent and auditable in its application
- Provides reward for organisations who are managing the Putting Things Right requirements effectively
- Is updated every year to reflect recent activity and progress
- Does not rely heavily on past events – providing emphasis on activity and behaviours of the last year.

General Medical Practice Indemnity



Scheme for GMPI

Legal & Risk Services are appointed by Welsh Government to operate the Scheme for General Medical Practice Indemnity ('GMPI'), launched on 1 April 2019.

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019.

The GMPI team aim to resolve any claim for compensation brought by a patient in relation to their clinical care under the NHS as fairly and as quickly as possible. Equally, the team recognises the importance of robustly defending claims where appropriate and of protecting GPs, their staff and their reputations.

Full details of the Scheme and Guidance and FAQs can be found on Legal & Risk's website.

The GMPI Team

Legal & Risk has a dedicated Primary Care Clinical Negligence Team (the GMPI Team) that operates the Scheme for GMPI. The lawyers specialise in managing clinical negligence claims against GPs and GP Practice staff across Wales and work closely with NWSSP's in-house GP advisors.

Since the GMPI team formed in April 2019, the team has been recognised for its work and has been shortlisted as finalists in 3 external legal awards:

- The Law Society Awards 2021, shortlisted in the 'In-House Team of the Year' category.
- South Wales Law Awards 2021, Finalist in the 'Personal Injury (clinical negligence)' category.
- Wales Legal Awards 2020, Finalist in the 'In-House Team of the Year' category.

Operation of GMPI

The GMPI team currently:

- operates an email and telephone helpline used by GP Practice staff and Health Boards across Wales seeking information about indemnity arrangements and support with clinical negligence complaints/ claims. There were over 4000 communications between 1 April 2019 to 31 March 2022.

- helps GP Practices to respond to patients' clinical concerns by providing guidance and support. The team seeks input from NWSSP's in-house GP medical advisors and feeds back to GP Practices any suggested learning. The team assisted GP Practices with approx. 360 patient concerns in the first 3 years of the Scheme (1 April 2019 – 31 March 2022). The guidance given by the team reflects NHS Wales Putting Things Right (PTR) concerns procedure.

- provides All-Wales training and bespoke virtual training to Health Boards and GPs/Practices/Trainee GPs across Wales. including 19 workshops and information sessions on the new scheme which were provided face to face to Health Boards and GP Practices across Wales prior to the Covid-19 pandemic. Other training topics have included tips for GP referrals during COVID-19, effective handling of patient concerns, the clinical negligence Legal Test, Case Studies, Confidentiality and Learning from Events in General Medical Practice. Training is mostly delivered virtually now.

- contributes articles to the Legal & Risk Newsletter sent to Health Boards and GP Practices.

- meets regularly with other NWSSP divisions (including for example NWSSP Primary Care Services, NWSSP Employment Services and the Welsh Risk Pool) and is a member of NWSSP's Primary Care Steering Group which has been set up to support sustainable primary care and to contribute to the development and delivery of the primary care model in Wales.

Through the support highlighted above, early input by the GMPI Team with patient concerns assists practices with resolving complaints at an early stage and help avoid clinical negligence claims where possible. However, it is recognised that some claims will, inevitably, be pursued, where for example, a Practice has made concessions, or the claimant feels aggrieved and pursues the matter regardless of the merits of the case. At 31st March 2022, 3 years after the introduction of the scheme, there have been only 2 patient concern matters, with which the GMPI team had assisted, that have developed into formal clinical negligence claims.

The GMPI claims are increasing, and good results have been achieved to date with GP Practices reporting back that they were "Very Satisfied" with the overall management of the case and provision of advice.

In 2021-22, the GMPI Team led the successful defence of a claim at Trial.

GMPI claim successfully defended at trial

The claim was brought against a GP Practice by a Litigant in Person who served court proceedings without notice. The amount of damages sought by the claimant was low, but it was important to defend the claim, to support the GP Practice staff who firmly disputed liability and to discourage similar unmeritorious claims.

This was an example of the GP Practice, the Health Board and GMPI Team working together to manage a sensitive and difficult claim brought against a particular GP Practice.

Learning from Events

The GMPI Team has worked with Welsh Risk Pool and NWSSP's in-house GP advisors to develop and implement a tailored process for learning from events in primary care GP matters – including shared learning between primary and secondary care on an All-Wales basis. Part of the procedure requires GP practices to commit to undertake any improvements identified and the Health Boards to monitor and verify the identified improvements, which helps to promote closer links and collaboration between primary care and secondary care and helps to improve patient safety.

The GMPI Team co-ordinates the robust learning from events process in General Medical Practice. It is hoped that this additional support service around learning from events will help to reduce incidents and prevent claims arising against Practices and Health Boards.

Existing Liabilities Scheme

In addition, Legal & Risk Services has been appointed by Welsh Government to operate the Existing Liabilities Scheme ('ELS') for eligible clinical negligence claims made against GPs and others working in a general practice setting as a result of an act or omission occurring prior to 1 April 2019.

ELS is only available where the medical defence organisation (which previously would have provided the indemnity) has completed an agreement to transfer these liabilities into the Scheme. To date, only two defence organisations have completed such an agreement. All eligible claims held by these defence organisations have been transferred into the Scheme and are being handled within the dedicated GMPI team.

Supporting Safety, Learning & Improvement

Safety & Learning Networks

The Welsh Risk Pool supports health bodies across NHS Wales to learn together and share experience and good practice through the Safety & Learning networks. These provide a forum for practitioners in patient safety, concerns management and service user feedback to improve practice across NHS Wales.

Safety & Learning Networks provide a forum for discussion and to achieve consensus and consistency across NHS Wales. The work of the networks is commissioned by the Welsh Risk Pool Committee. The work of the networks also report to the Listening & Learning from Feedback Group which is an all-Wales group coordinated by Welsh Government.

The principal aim of the networks is to provide an opportunity for NHS Wales staff to meet, share & learn. A core objective of the networks includes achieving consistency across NHS Wales. This provides opportunity for other national groups to request that a network considers a particular topic or area of concern.

There are a number of Safety & Learning Networks:

- Claims Management
- Complaints Handling
- Inquest Case Management
- NHS Wales Ombudsman Liaison Officers
- Redress Case Management
- Service User Feedback

In addition to the Safety & Learning Networks, the Welsh Risk Pool also facilitates the Head of Patient Experience Network, which is a membership group for senior managers within the Putting Things Right sector to meet, share and learn.

Facilitated by senior members of the Welsh Risk Pool team, networks are chaired by practitioners within the sector, operating on the principle of 'for the service, by the service'.

The Networks follow some core principles:

- **Topic Focus** to ensure all topics are given space to be discussed.
- **Practitioner Focus** attended and chaired by practitioners within the topic area.
- **Outcome Focus** enable practitioners in the field to consider service design and improvement through practical discussions on concepts for change and reaching a consensus of direction.
- **Space for consensus development** providing an environment for considered and worthwhile discussion; there are also opportunities for partner organisations, regulatory bodies and other interested parties to be invited to meetings in order that options can be explored.

During the pandemic, meetings transitioned to a virtual platform and are now routinely held using Microsoft Teams. This maximises the attendance and participation of members. Occasional meetings will be held in-person when this is considered to be necessary and beneficial to the items being discussed, but the majority of network meetings will remain on a virtual platform.

Network meetings are popular with members and attendance levels are excellent. The Welsh Risk Pool leadership team regularly receive compliments and thanks for providing the network process.

> "During the pandemic, having the networks available via Teams was an essential way for me to keep in touch with colleagues who were experiencing the same challenges as I was identifying. The meetings are really valuable."
>
> ***Claims Manager, NHS Wales***

> "The network has made a real difference in reaching a common way of working across NHS Wales. I have been able to shape our policy following discussion at the network."
>
> ***Redress Officer, NHS Wales***

During 2021/22, a total of thirty network meetings were held. During 2022, a meeting of all of the Network Chairs was held, led by the Chair of the Listening & Learning from Feedback Group.

This reflected on how the networks have matured:

- People are clear on the objectives of the networks and have identified the benefits of attending meetings
- The allocation of a dedicated facilitator has been incredibly effective in strengthening the maturing network system and promoting cross-working.
- The use of Share Point for document and information distribution has been a success.
- Task & Finish groups for specific topics have been extremely successful, and the networks are at a level of maturity where this can continue to happen.
- Positive feedback has been received from NHS Wales colleagues who attend other networks.

Learning from Events

The Welsh Risk Pool plays a key role in assuring learning action plans which are implemented from events arising from claims and redress cases. Additionally, sharing the learning across NHS Wales is a key aim of the Learning from Events programme.

A clinically led and multi-professional Learning and Advisory Panel (LAP) has been established as a recognised subcommittee of the Welsh Risk Pool. Chaired by established leaders from the Putting Things Right sector, the panel meets monthly to scrutinise the learning which has been implemented by organisations from cases where a decision to settle has been made. Each panel reviews around eighty cases.

The panel's recommendations are presented to the Welsh Risk Pool Committee. Where improvement in learning or action plans are needed, deferral of reimbursement of the costs of a claim is directed.

Where improvements in learning or action plans are not considered to be significant, decisions on recommending approval of learning and reimbursement of the costs in a case are delegated to a focussed panel – known as the amber review panel. This examines the feedback provided to a health body and confirms assurance that necessary steps have been taken.

For cases where the expenditure exceeds £1m, Medical Officers from Welsh Government attend the panel meetings and support the scrutiny of learning.

A quarterly newsletter, Doctrina, which targets themes, trends and identified cases of interest, is shared widely and well received by clinical leaders. The panel has identified that commonly occurring themes show that around a third of cases are in relation to missed or delayed diagnosis and this has been shared via the newsletter.

During 2021, the Welsh Risk Pool has worked closely with the NHS Wales Delivery Unit to migrate the Learning from Events for Nationally Reportable Incidents onto a single LFER form. This captures the essential information required by both organisations and ensures that local clinical teams have only one design and layout of the form to be familiar with.

During the 2021/22 period, the panel met monthly, with additional panels held if the caseload required it. A total of eighteen panels were held and over 1700 cases were scrutinised. The panel achieved effective multi-disciplinary attendance from various professions and specialities across NHS Wales.

> "The panel was a fascinating insight into the issues which led to claims. The meeting offered me an opportunity to review information from other organisations which I have been able to adopt in my own practice. I recommend that every junior doctor should attend a panel at least once during their training."
>
> ***Junior Doctor, NHS Wales***

> The panel is not just looking at paperwork, it carefully considers the circumstances which have led to a claim or redress case being brought against a health body and what actions have been taken to reduce the risk of a repeat incident. The input from clinical staff is vital to ensure that the panel is familiar with the operational context in which services are delivered.
>
> ***Panel Chair***

To enable organisations to focus on the response to the pandemic, the established deadlines for submission of Learning from Events Reports were relaxed in March 2020. Following careful analysis by the Welsh Risk Pool Committee, these have been reinstated. The deadline of 60 working days from a decision to settle a case to the submission of learning information is a key driver in ensuring prompt action is implemented to reduce the chances of a repeat event.

Clinical Reviews

The Welsh Risk Pool Committee commissions clinical reviews of topics or sectors when themes and trends are identified in cases. The reviews generally examine systems and processes which underpin the procedure or process being considered.

During 2021/22, the number of clinical reviews was reduced from the usual level due to the challenges arising from the pandemic. Three reviews were undertaken.

Venous Thromboembolism (VTE)

The review was commissioned in 2021, when the Learning Advisory Panel identified increased numbers of redress and clinical negligence cases relating to VTE.

Patients who are hospitalised and acutely unwell are widely recognised to be at a higher risk of developing a VTE than people in the general population. Given the increased numbers of hospital admissions of acutely unwell patients with Covid-19, there was concern that the number of cases presenting to the LAP would increase significantly. In the most recently available data, the Office of National Statistics shows that 369 people died in Wales, in 2020, from VTE related illness.

The review consisted of the analysis of patient records for patients admitted to hospital under medical specialty or selected surgical specialties. Criteria for the review were developed following discussion with members of the All-Wales Hospital Acquired Thrombosis (HAT) Committee. These were formulated to assess application of the current All-Wales Thromboprophylaxis Policy standards and to identify whether the patient had received a documented VTE risk assessment on admission, whether the VTE section of the Adult In-Patient Medication Administration Record had been correctly completed and whether thromboprophylaxis had been administered as prescribed.

The review found that compliance with correct completion of the Record for patients where thromboprophylaxis had been prescribed was excellent across all NHS Wales health bodies. However, in cases where thromboprophylaxis had not been prescribed, compliance with correct completion of the Record was poor.

Draft reports with recommendations and a proposed all-Wales WRP Standard for VTE have been circulated to health bodies. Development of a bespoke e-learning programme for VTE is almost complete and all health bodies have committed to implementing the all-Wales Thromboprophylaxis Policy. The Welsh Risk Pool Safety & Learning Team will actively support the HAT committee going forward.

The review will complete its work during 2022/23 and a re-inspection will be commissioned in the future by the Welsh Risk Pool Committee to assess progress.

Radiology (unexpected findings)

This review was a re-examination of the findings of a review we undertook in 2018. The review is triggered due to the sustained level of cases where a key finding is the failure of an organisation to act on findings of a radiological examination.

Analysis of the claims and redress cases related to this issue has identified that a radiologist or reporting radiographer may identify, and record, unexpected abnormal findings in their report but that the necessary clinical steps are not taken in response. This can lead to delays or missed opportunities for diagnosis and intervention and can result in significant harm for some patients. The review found this to occur more frequently in emergency department settings where staff who request radiological reports may not be on duty when the report is received, with the patient often already discharged.

Following the review in 2018, health bodies established working practices to address our findings and to try to reduce the potential for a case being missed.

Our analysis during 2021 identified that the issue continues to arise in claims and the established working practices in response to our recommendations are commonly manual tasks which are recognised to be at risk of error.

To help drive progress towards a digital solution, the NWSSP Medical Director has coordinated a task & finish group of radiology, emergency department and digital colleagues to explore opportunities within existing software that can be exploited to help reduce this risk.

Progress with this review will be reconsidered by the Welsh Risk Pool Committee in 2023/24.

Intrapartum Fetal Surveillance

Claim information highlights that allegations associated with failures in intrapartum fetal surveillance continue to be at an unacceptable level. One third of the 131 maternity claims, which were settled in the five year period between 2016 and 2020, featured intrapartum fetal surveillance as a contributory factor. Poor documentation, failure to escalate concerns and delay in acting were the significant factors involved in these cases. This amounted to over £86m in clinical negligence reimbursement.

The WRP commissioned the Safety & Learning Team to undertake a review of the application of the Intrapartum Fetal Surveillance Standards (2018) across NHS Wales. A preliminary review was undertaken in 2019. A national collaboration meeting was held in early 2019. The completion of the full review, which involves fieldwork throughout NHS Wales, has been delayed by the impact of the pandemic. The full review has now been completed and the findings are presented in a national report.

The review included fieldwork reviewing clinical notes of births between defined dates. The review also involved a survey of clinicians throughout NHS Wales in relation to documentation related to intrapartum fetal monitoring.

The review has identified areas of good practice and a number of areas where improvement can be implemented to reduce the risk of harm for women and babies. The main finding for improvement is that the quality and consistency of documentation related to fetal surveillance is limited and the risk of litigation remains unacceptable - the need is identified for a standardised approach which captures the documentation requirements in the standards.

A total of nine recommendations were made for the maternity services sector to collaborate on improvement. These will form a work plan for the WRP Safety & Learning Team during 2022/23.

Consent to Examination & Treatment

Litigation associated with issues related to the consent process continue to represent a regular feature in claims experienced in NHS Wales. To support organisations in providing information to patients, the Welsh Risk Pool has funded the provision of consent information for over ten years.

An improvement programme has been established to coordinate work in this area. During 2021/22, the programme has undertaken a series of work streams.

Library of Consent Information Leaflets

In July 2020, an alert was issued to ensure a more consistent national approach to procedure-specific patient information leaflets. It requires organisations to ensure that either EIDO procedure-specific patient information leaflets, where available, or procedure-specific patient information leaflets produced by recognised professional bodies or other national bodies, are provided to patients.

The library of leaflets has progressed through an all-Wales competitive tender, which was awarded to EIDO Healthcare. Evaluation of the tender responses was supported by a small cohort of clinicians and leaders from health bodies.

The programme team have continued to work with EIDO Healthcare to promote the availability of the Download Library across all health bodies. The team have also coordinated the facility for NHS Wales clinicians to provide feedback on current leaflets or request the development of new leaflets that are not currently available. This has led to the development and publication of a range of new leaflets.

Provision of consent information through the medium of Welsh is an important aspect of the programme. A structured piece of work has been coordinated by the NWSSP Welsh Language Services team to ensure that the standard of Welsh translation for every EIDO leaflet is reviewed and adjustments made where necessary to ensure that the translation meets the highest possible standards. Leaflets are presented in a bilingual format with Welsh and English versions side by side. A quality assurance function has been established, led by the NWSSP Welsh Language Services team, to monitor the translation of updated and new leaflets.

There has also been focussed engagement with Public Health Wales and the Welsh Blood Service, who develop national procedure-specific leaflets, to ensure these are available as a central resource through links on the Download library.

A further development in the materials available include access to Easy Read leaflets, in a bilingual format. These are leaflets aimed at providing key consent information to service users who may have additional needs or a learning difficulty.

Learning & Development in Consent

The programme team coordinated a national Webinar for clinicians in conjunction with EIDO on the question of

"How Can Technology Support the Consent Process During the Covid-19 Pandemic?"

Over 80 attendees joined the webinar; it was also recorded and made available as a resource via the NWSSP YouTube channel for those unable to attend.

Following a competitive tender exercise, the development of a bespoke e-learning package for NHS Wales healthcare professionals involved in the consent process has been implemented. This has included on-line video segments of key NHS Wales and Welsh Government leaders.

The SoundDoctor™ package is available via ESR and Learning@Wales for all NHS Wales staff.

Resources & Information

Webpages have been developed on both the internet and NWSSP intranet to provide an information resource on Consent to Examination & Treatment for both NHS employees and the public. This information includes links to the All Wales Model Policy and consent forms, e-learning and other useful documents or guidance (including legal and ethical resources during the Covid-19 pandemic).

All Wales Consent Group

The improvement programme is underpinned by the All Wales Consent to Examination and Treatment Group, which has representation from all health bodies. This national group has been established to:

- Coordinate and gain consensus amongst clinicians / Health Boards / Trusts about the Consent to Examination, Treatment and Screening process in Wales.
- Act as an advisory Group to the WRP Committee.
- Assist Welsh Health Bodies to provide assurance to their Board's and the WRP that relevant law and national guidance concerning consent is applied correctly within their Health Board / Trust.

Maternity Safety & Learning Programmes

Litigation associated with avoidable harm in maternity services continues to represent a significant proportion of claims expenditure across the NHS. Within Wales, approximately a third of Welsh Risk Pool expenditure is attributed to maternity services. It is clear that in addition to the significant litigation expenditure, the catastrophic harm caused to women and babies due to issues in care must be reduced.

The Welsh Risk Pool has established a Maternity Safety & Learning Board which drives improvement programmes aimed at reducing harm and litigation in maternity services.

CYMRU / WALES
PROMPT
PRactical Obstetric Multi-Professional Training
Hyfforddiant Aml-broffesiynol Ymarferol mewn Obstetreg

PROMPT Wales & Community PROMPT Wales

PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence-based training programme for all healthcare professions involved in the delivery of maternity services. It incorporates emergency simulation sessions and human factors training.

PROMPT Wales is a maternity safety programme funded and coordinated by the Welsh Risk Pool. It adapts the principles and resources used in PROMPT to meet the needs of services in NHS Wales and has been running in NHS Wales since January 2019. Introduced to reduce variation and standardise the quality of multi-professional obstetric emergency training across Wales, the overarching aim of PROMPT Wales is to improve outcomes for mothers and babies and reduce litigation costs associated with avoidable harm. Attendance on PROMPT Wales training is mandated by Welsh Government for all midwives, obstetric doctors and obstetric anaesthetists and is recognised in 'Maternity Care in Wales - A Five Year Vision for the Future (2019-2024).'

Each maternity unit in Wales runs courses regularly throughout the year in order to achieve the 95% attendance compliance set out in specially established PROMPT Wales Standards.

The Welsh Risk Pool has established a multi-professional national team to lead the implementation and sustained delivery of the programme. The national team have developed strong, collaborative relationships with maternity services and provide ongoing support by attending local training and providing quality assurance to health board leadership teams.
PROMPT Wales was briefly paused at the beginning of the pandemic but has continued in a hybrid format, with some lectures temporarily presented on a virtual platform. The fundamental principles of PROMPT training requires staff to train together in the clinical environment and a recovery plan to return fully to a standard delivery format is established.

For successful delivery of PROMPT Wales training, there needs to be effective local faculty within each health board. The national team organise Faculty Development training courses to enable health boards to maintain an optimum number of local multi-professional faculty to sustain the delivery of effective courses.

Building on the success of the PROMPT Wales programme, the Welsh Risk Pool has identified a need for a package to support community maternity services. Community PROMPT Wales has been developed specifically in Wales to offer a bespoke training experience for midwife-led teams. Having been developed and peer-reviewed to reduce variation and standardise the delivery and quality of community based obstetric emergency training, the programme is now being adapted for use across the UK and internationally.

Community midwives make up a third of the midwifery workforce in Wales, and along with an expected increase in community births in line with Welsh Government strategy – 'Maternity Care in Wales - A Five Year Vision for the Future (2019-2024),' this programme supports the development of community teams who are skilled to recognise and manage emergency situations efficiently and effectively.

Following a successful pilot, Community PROMPT Wales is now embedded into maternity services and attendance is mandated for those staff who work in midwife-led settings.

The programme has proven very popular - 99% of the 115 staff who completed an online survey found the training beneficial to their practice. Evaluation of survey results identify a 56% increase in the confidence of community midwives in managing an emergency following training.

Supporting PROMPT Wales training in higher education

Bangor University, Cardiff University, Swansea University and the University of South Wales have incorporated the principles of PROMPT Wales into the undergraduate midwifery programme, with PROMPT Wales trained lecturers in each institution.

Student midwives are also encouraged to attend PROMPT Wales training in health boards during their placements. This helps students become more familiar with the clinical environment and dynamics of dealing with an emergency in the clinical setting.

With university representation on the Maternity Safety & Learning Board, the national team and HEIW are collaborating with the higher education sector to standardise access to and experience of PROMPT Wales for student midwives in Wales.

Improving Outcomes

Research has shown that the PROMPT programme was associated with improvements in staff attitudes and organisational culture when rolled out in Victoria, Australia. To measure whether this could be replicated in NHS Wales, a Safety Attitude Questionnaire was distributed pre and post implementation of PROMPT Wales. Nationally, the mean scores from the sample demonstrates improvement in all domains: Teamwork, Safety Climate, Perception of Management, Job Satisfaction, Working Conditions and Stress Recognition. This recognises the contribution that PROMPT Wales training makes to cultural change, in addition to clinical skill, which collectively have been shown to improve the management of obstetric emergencies and safer outcomes.

The national team are currently capturing and validating data streams to enable the analysis of the PROMPT Wales principles on clinical outcomes. Preliminary data indicates that there is improvement since the commencement of PROMPT Wales in 5 minute APGAR score <7. The full suite of clinical outcome measures include:

- 5-minute APGAR <7 (Term births)
- 5-minute APGAR <7 (Preterm births)
- Hypoxic Ischaemic Encephalopathy Grade 2 + 3
- Shoulder dystocia (as a denominator for BPI)
- Brachial Plexus Injury at birth
- Brachial Plexus Injury at 12 months
- 1500ml PPH (Primary)
- 2500ml PPH (Primary)
- Maternity admissions to level 3 care

The successful implementation of PROMPT Wales is attributed to the collaborative approach between the Welsh Risk Pool, Wales Maternity & Neonatal Network, the PROMPT Maternity Foundation and all seven NHS Wales health boards.

The success of this national programme has been recognised by Professor Tim Draycott, Joint PROMPT Maternity Foundation Lead, Consultant Obstetrician at North Bristol Trust and Vice President of the Royal College of Obstetricians and Gynaecologists.

> PROMPT Wales has provided a consistent approach to multi-professional training for all units and services across Wales with national leadership by the Welsh Risk Pool. Furthermore, the implementation of PROMPT Wales at unit level has been the most coherent and robust of any maternity training programme in the literature, even with the challenges of the geographically widespread sites and the rapid timescale. Finally, I consider that the success of the programme has largely been due to an ambitious and joined up approach that is a model for scaling future programmes internationally.
>
> ***Prof Tim Draycott***

Intrapartum Fetal Surveillance

Documentation is a recurring theme in WRP claims related to issues with fetal monitoring. This includes issues relating to the standard of both cardiotocograph (CTG) and intermittent auscultation (IA) documentation, including decisions on when to clinically intervene.

Following the completion of the clinical review into Intrapartum Fetal Surveillance, it has been identified that there is divergence of practice in relation to the form and content of CTG and IA documentation. Training was also found to have considerable variation.

The team led an all-Wales survey, which was completed by 264 maternity staff to generate staff attitudes around the use of stickers which are used to categorise CTGs.

The team have developed an all-Wales virtual workshop training package on fetal monitoring during labour. This unique training focuses around a 'labour ward board,' whereby the multi-professional team will need to make collaborative decisions and prioritise care, whilst remaining situationally aware of the labour ward as a whole. Human factors are incorporated in response to national reports which demonstrate that a loss of situational awareness contributes to over 70% of avoidable neonatal brain injury or death.

Members of the national team are represented on the Wales Maternity & Neonatal Network Guideline group, reviewing the all-Wales Intrapartum fetal surveillance Standards. The group are working on the development of an all-Wales CTG documentation tool, and are also discussing the best approach to training on intrapartum fetal surveillance. As part of these discussions, the virtual workshop training package will be considered as one option.

Once for Wales Concerns Management System

The Once for Wales Concerns Management System Programme was developed from the recommendations made by Keith Evans in the report commissioned by Welsh Government – "The Gift of Complaints". The programme aims at bringing consistency to the use of the electronic tools used by all NHS Wales health bodies when handling concerns to investigate and improve quality & safety.

System Rheoli Pryderon Unwaith dros Gymru

Once for Wales Concerns Management System

The programme moves organisations away from using independently configured systems to a series of products with a common Once for Wales configuration and design. Following a successful procurement exercise, two products currently form the Once for Wales system – Datix Cymru and Civica Experience Wales. These are bespoke products, adapted to meet the needs of NHS Wales.

The functionality and configuration of the various modules within the software are designed by a series of workstreams which consist of subject matter experts from NHS Wales organisations. This enables the system to be designed by the service, for the service.

Datix Cymru

The Datix Cymru product is a cloud-based software tool with multiple modules that have been adapted, configured and implemented specifically for NHS Wales. Fig10 outlines the core functionality of the product.

RLDatix

Datix Cymru

- ✓ Incidents
- ✓ Inquest Cases
- ✓ Safdety Alerts
- ✓ Risk Registers
- ✓ Complaints
- ✓ PALS Enquiries
- ✓ Mortality Reviews
- ✓ Safeguarding
- ✓ Redress Cases
- ✓ Claims Management
- ✓ Medical Examiners
- ✓ Cyber Resilience Reports

Fig10 Core Functionality of Datix Cymru

The Datix Cymru programme is divided into three phases of implementation. Phase 1 introduces the systems and coding processes on a Once for Wales basis and all health bodies are now using the platform. Phase 1 modules include Incidents, Complaints, Claims & Redress, PALS, Inquests, Mortality Reviews. Phase 2 during 2022/23 aims to implement the risk registers and safeguarding functionality.

The phase 1 implementation also included some specific functionality for specialist services in NHS Wales. The Wales Medical Examiner Service utilises a dedicated Datix Cymru module. The Cyber Resilience Unit, which oversees the Security of Networks and Information Systems Regulations, also uses a bespoke configuration of the Datix Cymru product to capture and analyse data in relation to cyber security matters.

Using a cloud-based platform, the Datix Cymru system enables primary care contractors and key stakeholders to use the system – facilitating an integrated approach.

With the decommissioning of the National Reporting & Learning Service, Welsh Government has requested that interim solutions are put into place to enable primary care contractors to report patient safety matters, and this has been particularly embraced by the pharmacy services in NHS Wales. This will be further expanded in 2022/23.

Capture, Categorisation & Coding of information is a vital element of the Datix Cymru system. By aligning all of the coding used across all organisations, NHS Wales has generated a dataset that enables structured analysis of the causal factors of things that have gone wrong and when things go well – sharing best practice throughout all health bodies.

The first national coding dataset was introduced in 2020 and this is regularly reviewed by a dedicated workstream of subject matter experts. All organisations are now utilising the national coding dataset for Incidents and these will be incorporated into the other modules during 2022/23.

The programme has established a dedicated workstream to consider Intelligent Monitoring, Dashboards and Data Analysis – identifying the most effective reporting tools that can provide strategic, organisational and operational information to drive safety and quality improvements. With all organisations utilising a bespoke NHS Wales coding dataset, this enables reports that have not been possible to produce before to be obtained from the system.

The power of the Datix Cymru system enables the creation and configuration of specific Investigation Tools, bringing consistency to the methodology used to investigate where things have gone wrong. This work has commenced with a specialist workstream introducing the Yorkshire Framework of causal factors. The development of specific investigations tools will be expanded in 2022/23.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduces a Duty of Candour within Wales. During 2021/22, the OfWCMS Central Team have worked with key stakeholders and Welsh Government to ensure that the Datix Cymru system is fully ready to support this important new duty. The workflows and design of the Duty of Candour reports have been developed with the support of a workstream of subject matter experts. The system enables primary care contractors and other providers to report cases where the duty of candour has been triggered to their commissioning health bodies.

During 2021/22, over 30,000 Incidents were reported using the Datix Cymru system as organisations migrated to the new platform. Approximately 20,000 Complaint and Early resolution Investigations were conducted using the system. Early results indicate that the all-Wales workflow and consistency coding provides higher quality data.

As the system becomes embedded further, it is estimated that over 180,000 incidents will be reported and managed through the system each year.

Service User Feedback

As the Keith Evans report reminds NHS Wales, obtaining feedback from users of our services is a vital element to be able to identify what is going well and where there are areas for improvement.

The Once for Wales Concerns Management System has established the Civica Experience system in each health body and some national groups. This common platform enables structured surveys to be designed and distributed to service users, gathering real-time valuable feedback for service leads and clinical leaders. Through integration with local ICT systems, survey information can be directed and focussed to the right recipients.

The Civica Experience Wales product has a wide range of features, based on a dedicated survey design & analysis tool. Multiple methods of communication with service users are available, including dedicated apps which are installed on portable devices, text messaging to service users' known telephone numbers and interactive voice response messaging. The functionality of the multi-lingual product is outlined in Fig11.

CIVICA

CIVICA Experience Wales

- ✓ Survey Design
- ✓ Results Analysis
- ✓ SMS Messaging
- ✓ IVR Messaging
- ✓ Survey App
- ✓ Local Feedback Capture
- ✓ Children and Young People Surveys
- ✓ Patient Stories

Fig11 Available Functionality of Civica Experience Wales

Once for Wales Governance

The Welsh Risk Pool has worked with all health bodies and national groups to ensure that the information governance arrangements and cyber security requirements relating to the Datix Cymru and Civica Experience Wales are firmly in place. During 2021/22 national Data Protection Impact Assessments have been approved for all elements of the system and these remain under regular review.

Led by a Central Team of system experts which is hosted by the Welsh Risk Pool, each health body has trained Local System Leads to support organisations delivering training to staff, setting up the access to data for staff and helping to get the most from the system.

The Once for Wales Concerns Management System is an excellent example of NHS Wales organisations working collaboratively. The governance structure, established to maintain consistency in system setup and configuration, includes a Programme Board which is chaired by a Chief Executive of one of the health bodies, a Steering Group which formulates and guides the development and implementation plan and a Content & Governance Group, which provides oversight of the system developments requested by organisations.

Assurance – Putting Things Right

The Welsh Risk Pool conducts assurance reviews on behalf of Welsh Government in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations.

These reviews are designed to help health bodies comply with the requirements set out in the PTR regulations, and to develop action plans to address any areas for development. The outcomes of the reviews are also included as an indicator that determines each health body's contribution to the risk sharing agreement.

Prior to the pandemic, the reviews were paused to enable a review of the methodology and scoring & rating process – to ensure it provides the most useful information to leadership teams as possible. Work has been undertaken with the Head of Patient Experience Network to identify the key areas of focus for the reviews.

The reviews involve careful analysis of complaint investigation records, policy and procedure documentation and data held in systems. Using a peer-review approach to share best practice across NHS Wales, staff from health bodies join specialist reviewers from the Welsh Risk Pool and Legal & Risk Services in conducting the assessment.

The reviews were not carried out during 2020 or 2021 to enable organisations to focus on the response to the pandemic. Now that the protective measures associated with the pandemic have been relaxed, it is possible to recommence the WRP Review process.

WRP Assessments 2022/23

It is intended to carry out a review with each health body in NHS Wales during 2022/23. To enable organisations to share and coordinate learning and improvement, the data selected as part of the review will relate to concerns handled during January to March 2022. It is intended that the reviews for 2022/23 will be carried out during Q3 or Q4 of the financial year.

The review will consider:

- The health body's policy & procedures for handling concerns.
- The timeliness of complaint investigations.
- The quality of complaint investigations and responses.
- Arrangements for handling concerns about primary care providers.
- The application of the all-Wales workflow within Datix Cymru for concerns.
- Appropriateness use of internal and external expert opinion.
- Suitability of decisions whether there is a qualifying liability in a matter.
- Compliance with the duty to be open, which will become the Duty of Candour in 2023.
- Arrangements for sharing lessons learned from a concern across the organisation.

Supporting the response and recovery from Coronavirus

The pandemic has placed unprecedented pressures onto health and care services in Wales and required organisations to work in new and innovative ways.

To facilitate alternative models of NHS operational delivery needed during the pandemic, the Welsh Risk Pool and Legal & Risk Services have been instrumental in supporting Welsh Government and health bodies by producing guidance and frameworks to support decisions on indemnity.

During the pandemic we established a hub of experienced lawyers to provide advice on legal issues arising from the Coronavirus pandemic. We ensured that claimants were not negatively impacted where possible by offering interim payments of damages and agreeing extensions of time.

This work continues with focus moving to analysis and communication across Wales of the impact of the context of the pandemic on the usual legal tests of negligence.

This is relevant to clinical negligence claims and all Putting Things Right investigations where qualifying liability is being investigated by NHS bodies in respect of events which occurred during the pandemic. It is essential that NHS treatment affected by pandemic is judged in the context in which it was provided and not against pre-pandemic standards. Specialist teams within Legal & Risk Services have been set up to lead on these complex legal issues. This is co-ordinated by Head of Healthcare Litigation Sarah Watt.

Legal & Risk Services is supporting health bodies in their investigations and decision making in respect of the hospital acquired Covid-19 infections which occurred across Wales. It actively supported the Delivery Unit in the establishment of the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 and will continue to support all health bodies in these investigations.

Impact & Reach of our Professional Services

Our professional services are designed to actively support health bodies and other clients in providing modern, fit for purpose service.

Clinical Negligence Team

The team is made up of over 50 solicitors and legal executives with extensive experience in defending clinical negligence claims against the NHS in Wales. We are recognised for our excellence and in-depth knowledge of each NHS body we represent within Wales. Most of our lawyers have been with Legal & Risk Services for many years and are experts in the fields of multi-million pound claims, complex litigation and every area of litigation we deal with. We provide training to all clients on a range of topics.

The team supports many All-Wales initiatives and is actively involved in national groups. Client relationships are extremely strong, which is essential in order to defend clinical negligence claims to trial and also to obtain consensus in respect of those claims which should be settled.

The Team aims to settle indefensible cases fairly and quickly in order to minimise anxiety for both patients who have been injured by negligent treatment and NHS staff involved in the legal claims. The strategic focus is to increase the use of alternative dispute resolution procedures, and avoid legal proceedings, in order to save costs and time; review the management of our high value claims and identify any improvements to promote robust financial reserving and improve efficiency; to focus on our lowest value claims and prepare for the likely introduction of fixed recoverable costs in clinical negligence claims next year.

The team also supports all work done by health bodies in respect of the PTR regulations, running regular clinics, providing All-Wales and individual client training and advising on the most complex matters.

The introduction of the Head of Healthcare Litigation will strengthen the strategic focus and drive change to improve efficiencies across Wales in respect to the management of clinical negligence claims.

Commercial, Regulatory and Procurement Team

Our Commercial, Regulatory and Procurement Team have an exceptional number of years of experience in dealing with a vast array of legal disputes, overseeing the procurement process and advising on procedural fairness throughout NHS Wales.

The team advise health bodies throughout Wales on all manner of issues, both contentious and non-contentious, which includes Commercial (contractual arrangements) and public law matters (judicial reviews). We also help the NHS understand the complexities of the maze of regulation that exists.

Below is a non-exhaustive list of some of the topics that we are able to advise on:

- Commercial contracts
- Procurement law (Advice on regulations and procedure)
- Procurement documentation (Advice on drafting Invitations To Tender (ITT), Pre-Qualification Questionnaires (PQQ) and specification)
- Procurement challenges
- Outsourcing treatment and services
- Intellectual Property
- Regulatory law
- Public contract law (General Medical Services/General Dental Services Contracts)
- Public/Private partnership (National Cancer Service)
- Judicial Review of decisions
- Commercial Litigation
- Residency disputes
- Disputes between public authorities regarding funding
- Dispute resolution
- Policy drafting
- Construction
- Criminal
- Civil Fraud
- Injunctions
- Defamation
- Transfer of Undertakings & Protected Employees (TUPE)
- Information law (Data Protection and FOI issues).
- Debt collection
- International law (Memoranda Of Understanding & Service Level Agreements with foreign governments).

Personal Injury Team

The Personal Injury (PI) team is formed of specialist solicitors and chartered legal executives. It deals with personal injury claims across all health bodies. The claims dealt with can range from relatively low value slip and trip claims to more complex matters such as mesothelioma and incidents resulting in permanent injuries.

The team also provides advice to clients in the following fields:

- Employers and Public liability
- Work related stress
- Bullying and harassment
- Violence & Aggression
- Industrial disease, including
- Asbestos
- Hearing loss
- Object and person manual handling
- Repetitive strain injury
- Defective equipment
- Infection Control
- Slip and trip cases

The PI team work cohesively to deliver an excellent service to our clients, including a bi-annual education day which aims to enhance the experience and understanding of NHS leaders.

The team also provides valuable analysis of trends as well as focusing upon learning lessons and giving practical risk management advice in areas that have been identified as vulnerable. We firmly believe that prevention is better than cure.

The team has also become involved in a range of specialist projects; most recently being the NHS Anti-Violence Collaborative titled "Obligatory Responses to Violence in Healthcare". It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

Complex Patient (Court of Protection)

Our Complex Patient team is led by Gavin Knox; a specialist team which is comfortable dealing with highly complex and sensitive clinical situations where a patient's life or liberty might be at stake. Early intervention will often improve outcomes for patients. This may be by helping to ensure health board staff are acting in the best interests of the patient, or by resolving disputes that can in themselves cause distress to the individual.

- Mental Capacity Act and Best Interests for Children - there is a growing need for NHS staff to understand and implement the principles and provisions of the Mental Capacity Act. Our team offers a rapid and reasoned response to any capacity or best interests related query. By engaging early with clinicians, patients and families, we can usually assist in resolving disputes or ethical dilemmas and avoid the need for applications to be made to Court. The same applies to disputes about medical treatment or end of life decisions for children.

- Deprivation of Liberty - The full impact of the Supreme Court decision in Cheshire West, that redefined what amounted to a deprivation of liberty, is still being realised with enormous impact on NHS resources. We help health boards avoid unlawful deprivations and provide representation in the Court of Protection when a patient appeals against their detention.

- End of Life Decision Making (adults and children) - There are no more important decisions than those relating to the end of life. We are regularly instructed where disputes arise between clinicians and patients or their family about what treatment can lawfully be given.

- Mental Health - We help staff navigate the legislation and the difficult conflicts and interfaces with the Mental Capacity Act and Deprivation of Liberty.

- Court of Protection & High Court Applications - Not all issues can be resolved locally and ultimately some decisions need to be made by a Court. Often these can be highly contentious, complex, and emotive cases with the health, liberty or life of a vulnerable adult or child in the balance. We have extensive experience of making applications to both the Court of Protection and the High Court, each with their own particular rules and procedures. We offer a service that aims to resolve disputes quickly and sensitively to preserve therapeutic relationships with patients or families.

The Complex Patient team work on a real-time basis and are often involved in out of normal hours discussions, providing advice to clinicians dealing with these issues on a day to day basis.

Inquests Team

We have a dedicated team that is able to support health bodies when preparing for and participating in coronial inquiries and inquest hearings

We support the whole inquest process and focus our legal input on those that raise complex Human Rights issues such as suicides, deaths in prison or involving patients in mental health detention, potential gross negligence, or systemic organisational issues.

Our experienced lawyers support health bodies in triaging inquest matters to determine those which will benefit from formal legal input and representation.

Employment Team

Our Employment Team is led by Sioned Eurig. Since its inception in 2012, the team has acted for health boards and Trusts in a wide and diverse range of Employment Tribunal and County Court cases. The team has also had the privilege of advising on high level strategic policy issues.

The team can help with all types of claims in the Employment Tribunal including, but not limited to:

- Unfair dismissal (conduct and capability)
- Various types of discrimination (disability, sexual orientation, race, age, gender etc)
- Unlawful deduction of wages
- Holiday pay
- Whistleblowing
- Pension
- Agency worker rights
- Doctor disciplinary cases

The team can also help with the with wide range issues facing busy healthcare services:

- Interpretation of policies and procedures on an All-Wales level
- Issues arising out of the employment relationship (including advising on grievances and disciplinary hearings) including termination of employment
- Family friendly policies (i.e. Shared Parental Leave regime)
- Clinician banding appeals
- Severance packages and drafting settlement agreements
- The Transfer of Undertaking (Protection of Employment) Regulations 2006
- Voluntary Early Release Schemes and queries
- Doctor disciplinary issues
- All Wales matters in association with the Welsh Government
- Employment status
- Consultations and Redundancies
- Union Recognition
- Restructures

As well as helping clients to manage cases when things go wrong, the team also works with clients to train Workforce teams and line managers to reduce the risk of claims. Employment law is constantly evolving.

Our Employment team can offer a wide range of educational talks and seminars that can be delivered at our fully equipped premises. We are also able to tailor quarter, half or full day packages at a location to suit our client. Recent topics include:

- Training on the Upholding Professional Standards Policy
- Disciplinary investigations training
- Employment updates
- TUPE training
- Dignity at Work
- Whistleblowing

Property Acquisitions, Disposals and Leases Team

Our property team provides advice across the NHS Wales estate, delivering a quality service at competitive rates. The team has extensive knowledge and experience in commercial property and of the NHS Wales estate.

The team works closely with NWSSP Specialist Estates team and undertakes a range of work, which encompasses:

- Leasehold acquisition of offices on behalf of NHS Trusts and health boards;
- Lease re-gears, including varying principal lease terms and break dates, as well as general management work (licences to alter etc.) in support of tenant works;
- Freehold sales of surplus commercial and residential properties, including provisions to protect future development rights of adjacent land retained by NHS Wales;
- Freehold acquisitions in connection with large-scale developments by NHS Trusts and Health Boards; and
- General, one-off property queries on sundry matters, including in the primary care field.

Savings & Successes

We are justifiably proud of the services provided by all of the staff and teams with the Welsh Risk Pool and Legal & Risk Service.

We regularly monitor the savings that the professional influence of our teams brings to the NHS in Wales. This includes reducing legal costs in cases, successfully defending claims and other matters, influencing policy areas to reduce costs and delivering training to managers and staff throughout the NHS.

Professional Influence Savings

In 2021/22, our professional influence savings and success were:

£74,054,226.00

This is expenditure that would otherwise be incurred by NHS Wales and would not be able to be spent on the provision of care.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

SUPPLEMENT

ORGANISATION	Powys Teaching Health Board

This supplement is intended to provide organisation-specific data for comparison against the all-Wales data provided in the main Annual Review document.

Open Clinical Negligence Claims

Fig1 in the Annual Review highlights the number of clinical negligence matters that are open at the end of each of the last ten financial years – to outline a trend analysis. The information is provided here with the health body's data included.

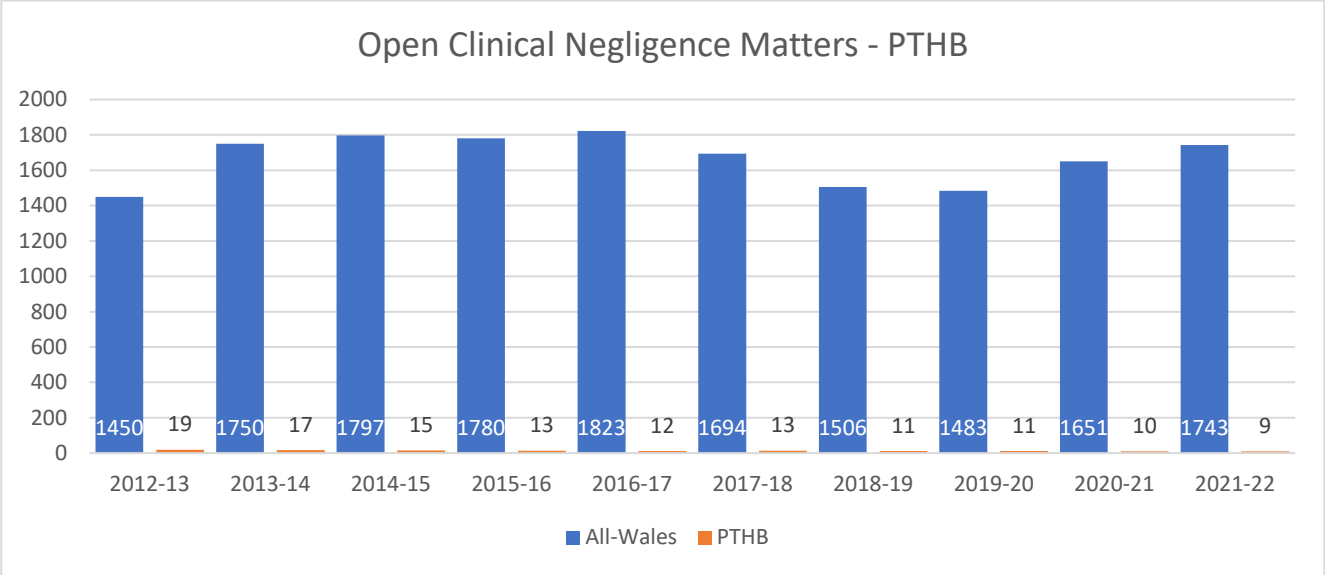

Fig1 Open Clinical Negligence Claims, including health body data

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
All-Wales	1450	1750	1797	1780	1823	1694	1506	1483	1651	1743
PTHB	19	17	15	13	12	13	11	11	10	9

Data1 Open Clinical Negligence claims, including health body data

- NB a proportion of clinical negligence and personal injury matters identified as Powys Teaching Health Board include cases which are related to care and services provided by Former Health Authorities.

Clinical Negligence Claims closed without Damages

Fig2 within the Annual Review outlines the all-Wales proportion of cases which are successfully defended and closed without damages being awarded over the last three financial years. The information is provided here with the health body's data included.

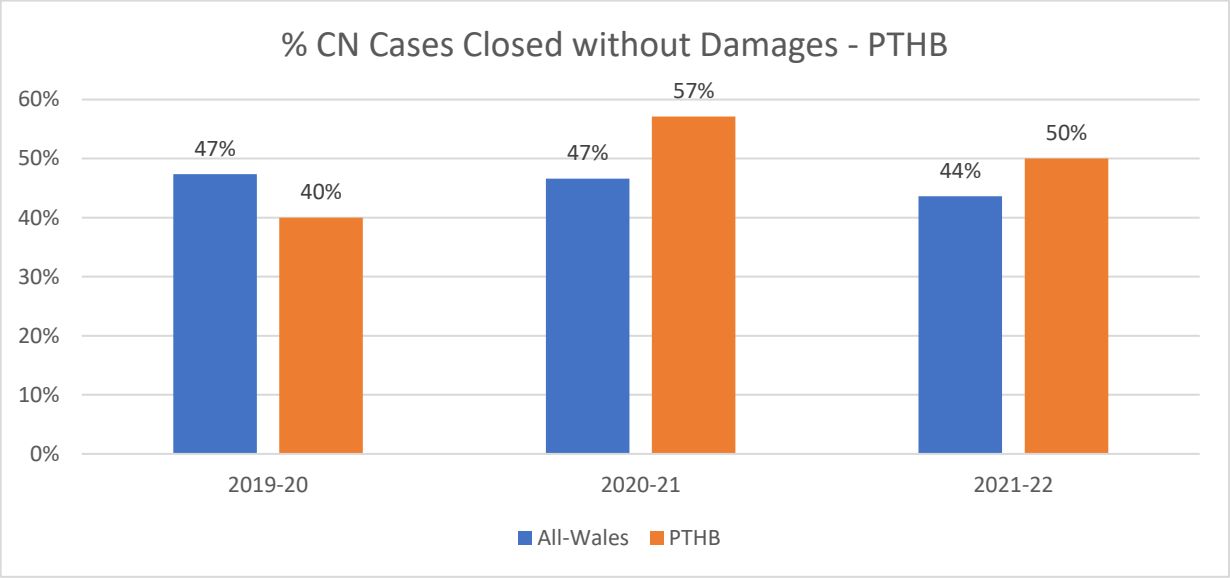

Fig2 % of Clinical Negligence Claims closed with Damages, including health body data

	2019-20	2020-21	2021-22
All-Wales	47%	47%	44%
PTHB	40%	57%	50%

Data2 % of Clinical Negligence Claims closed with Damages, including health body data

- NB a proportion of clinical negligence and personal injury matters identified as Powys Teaching Health Board include cases which are related to care and services provided by Former Health Authorities.

Principal Clinical Specialties in Clinical Negligence Matters

Table1 in the Annual Review outlines a breakdown of the principal clinical specialty identified in the clinical negligence matters being managed during 2021/22. The information is provided here with the health body's data included.

Specialty	All-Wales	All-Wales %	PTHB	PTHB %
Administration, Estates & Business Services	3	0.13%		
Ambulance / Paramedics	28	1.24%		
Anaesthetics	18	0.80%		
Audiology	1	0.04%		
Cardiology	32	1.42%		
Cardiothoracic Surgery	8	0.36%		
Colorectal Surgery	17	0.76%	1	7.69%
Cytology	7	0.31%		
Dental	11	0.49%		
Dermatology	12	0.53%		
District Nursing & Health Visiting	8	0.36%	1	7.69%
Ear Nose & Throat	34	1.51%		
Emergency Departments & Assessment Units	261	11.60%	1	7.69%
Gastroenterology	26	1.16%		
Genetics	2	0.09%		
Genitourinary Medicine	3	0.13%		
Geriatric Medicine	10	0.44%		
GP Out of Hours	8	0.36%		
Gynaecology	123	5.47%		
Haematology	12	0.53%		
Maternity Services	399	17.73%	3	23.08%
Maxillofacial	10	0.44%		
Medicine	84	3.73%		
Mental Health & Psycology	52	2.31%		
Nephrology	11	0.49%		
Neurology	24	1.07%		
Neurosurgery	25	1.11%		
Nursing Care (Secondary Care)	48	2.13%		
Oncology	32	1.42%		
Opthalmology	66	2.93%	1	7.69%
Oral & Maxillofacial Surgery	10	0.44%		
Orthopaedics & Trauma	304	13.51%	1	7.69%
Paediatrics	64	2.84%	2	15.38%
Pathology, Histology & Microbiology	9	0.40%		
Physiotherapy	12	0.53%		
Plastic Surgery	3	0.13%		
Podiatry	4	0.18%		
Primary Care & General Practice (exl GMPI)	47	2.09%	2	15.38%
Radiology	52	2.31%		
Respiratory	8	0.36%		
Rheumatology	6	0.27%		
Speech Therapy	1	0.04%		
Surgery	183	8.13%		
Urology	48	2.13%		
OTHER / UNSPECIFIED	124	5.51%	1	7.69%
TOTAL	2250		13	

Table1 Summary of Principal Clinical Specialties in CN Matters, including health body data

- NB a proportion of clinical negligence and personal injury matters identified as Powys Teaching Health Board include cases which are related to care and services provided by Former Health Authorities.

Open Personal Injury Matters

Fig4 in the Annual Review outlines the number of personal injury matters that are open at the end of each of the last ten financial years – to outline a trend analysis. The information is provided here with the health body's data included. The Annual Review provides the data for the last seventeen financial years. However, due to the reorganisation of NHS Wales in 2009, data in the supplement is only provided from 1st April 2009.

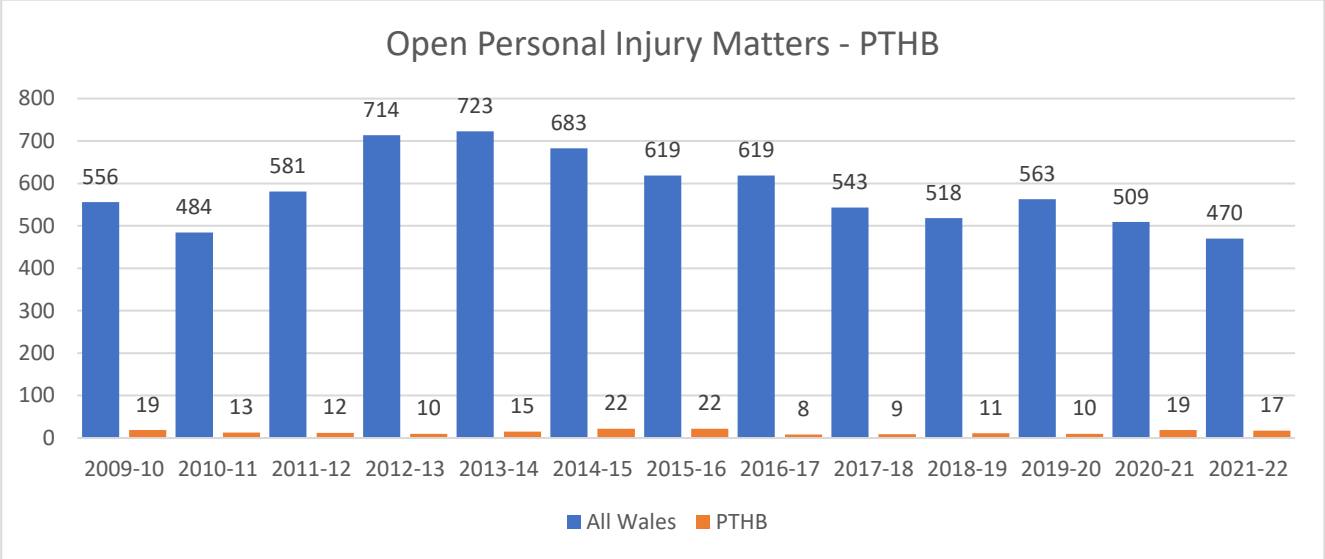

Fig4 Open Personal Injury Claims, including health body data

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
All Wales	556	484	581	714	723	683	619	619	543	518	563	509	470
PTHB	19	13	12	10	15	22	22	8	9	11	10	19	17

Data4 Open Personal Injury Claims, including health body data

- NB a proportion of clinical negligence and personal injury matters identified as Powys Teaching Health Board include cases which are related to care and services provided by Former Health Authorities.

Personal Injury Claims closed without Damages

Fig5 within the Annual Review outlines the all-Wales proportion of cases which are successfully defended and closed without damages being awarded over the last three financial years. The information is provided here with the health body's data included.

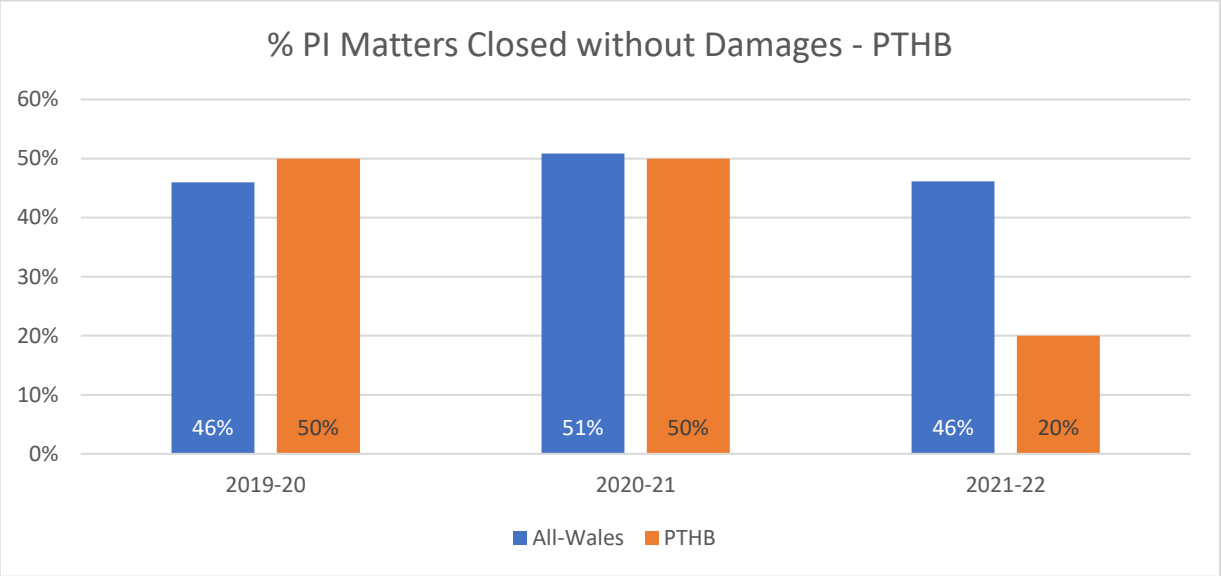

Fig5 % of Personal Injury Claims closed with Damages, including health body data

	2019-20	2020-21	2021-22
All-Wales	46%	51%	46%
PTHB	50%	50%	20%

Data5 % of Personal Injury Claims closed with Damages, including health body data

- NB a proportion of clinical negligence and personal injury matters identified as Powys Teaching Health Board include cases which are related to care and services provided by Former Health Authorities.

Summary of Redress Cases

Fig6 in the Annual Review outlines the number of Redress Cases being managed across NHS Wales over the last three financial years. This information is gathered from forecast information submitted by health bodies. The information is outlined here with the organisation-specific data included.

PTHB	01/04/19 - 31/03/20		01/04/20 - 31/03/21		01/04/21 - 31/03/22	
Period	*As at 31/03/20*		*As at 31/03/21*		*As at 31/03/22*	
	All-Wales	PTHB	All-Wales	PTHB	All-Wales	PTHB
Ongoing cases	624	12	567	16	531	20
Reimbursement cases	111	0	114	5	118	2
Closed Cases	232	2	235	4	226	7
Transferred Out	22	0	47	2	38	1
Withdrawn	3	1	17	1	10	3
Total of all cases per year	992	15	980	28	924	33

Data6 Redress Cases for last three years, with health body data included

Periodical Payment Orders

Fig7 within the Annual Review outlines the number and value of Periodical Payment Orders (PPOs) over the last five years. This is re-created here.

Additionally, a breakdown of the number of PPOs relating to care by each health body is provided and the number of PPOs & value of payments made is outlined.

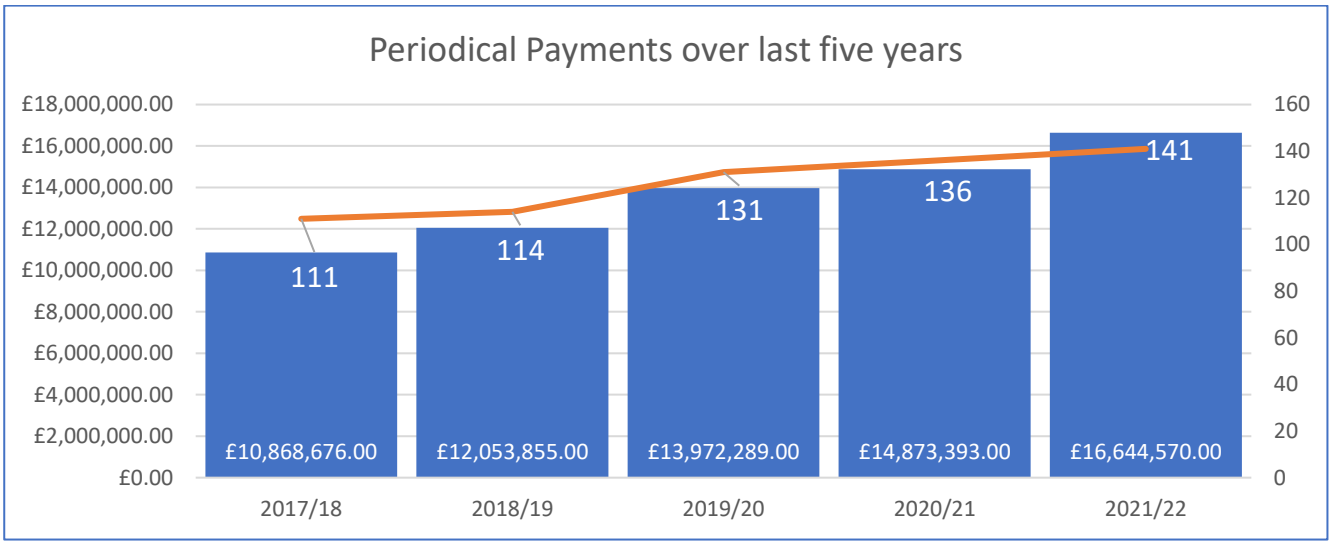

Fig7 Value & Number of PPOs over the last five years (all-Wales data)

Number and Value of PPOs		
	PAYMENTS	No.
All-Wales	£16,644,570	141
PTHB	£1,737,025	22

Data7 Value and Number of PPOs, with health body data included

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