Audit, Risk and Assurance Committee

Tue 08 October 2024, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARAC_Agenda_08OCTOBER2024 Final.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 09 July 2024 for approval

ARAC_1.3_Draft Minutes 09 July 2024.pdf (9 pages)

1.4. Committee Action Log

ARAC_1.4_Action Log.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

There are no items for inclusion in this section

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Internal Audit Progress Report 2024/25

Head of Internal Audit

ARAC_3.1_Cover Report Internal Audit Progress Report.pdf (2 pages)
ARAC_3.1a_ Internal Audit Progress Report October 24.pdf (18 pages)

3.2. Internal Audit Reports:

Head of Internal Audit

3.2.1. End of Life Care Services (Reasonable Assurance)

ARAC_3.2a_ EOL Final Audit Report.pdf (15 pages)

3.2.2. Integrated Performance Framework (Substantial Assurance)

ARAC_3.2b_ Integrated Performance Framework Final Audit Report_.pdf (9 pages)

3.2.3. Integrated Plan Development Process (Reasonable Assurance)

ARAC_3.2c_Integrated Plan Development Final Report.pdf (10 pages)

3.2.4. Cleaning Standards (Reasonable Assurance)

ARAC_3.2d_Cleaning Standards Final Report.pdf (18 pages)

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3.3. External Audit Progress Report 2024/25

External Audit

- ARAC_3.3_Audit Wales Update October 2024.pdf (11 pages)

3.3.1. Review of Cost Savings Arrangements

- ARAC_3.3b_Review of Cost Savings Arrangements - PTHB Management Response.pdf (4 pages)
- ARAC_3.3a_2023 Review of Cost Savings Arrangements - PTHB.pdf (24 pages)

3.4. Audit report – roles and responsibilities

Presentation *Director of Corporate Governance*

3.5. Audit Recommendation Tracker

Attached *Director of Corporate Governance*

- ARAC_3.5_Audit Recomendations Cover Paper.pdf (5 pages)
- ARAC_3.5a_Internal Audit Recomendations COMPLETED since previous report.pdf (1 pages)
- ARAC_3.5b_Internal Audit Recommendations NOT YET DUE since previous report.pdf (4 pages)
- ARAC_3.5c_Internal Audit Recommendations that remain OUTSTANDING.pdf (2 pages)
- ARAC_3.5d_External Audit Recommendations NOT YET Due.pdf (3 pages)
- ARAC_3.5e_External Audit Recommendations that remain OUTSTANDING.pdf (1 pages)

3.6. Board Assurance Framework

Presentation *Director of Corporate Governance*

3.7. Losses and Special Payments Report

Attached *Director of Finance, Information and IT*

- ARAC_3.7_Losses and Special Payments Interim Report 2024-25.pdf (7 pages)

3.8. Single Tender Waivers (including extensions to contracts)

Attached *Deputy Chief Executive/Director of Finance,Capital and Support Services*

- ARAC_3.8_Application for Single Tender Waiver Oct 24.pdf (3 pages)

3.9. Counter Fraud update

Head of Local Counter Fraud

- ARAC_3.9_Counter Fraud Update Cover Report.pdf (2 pages)
- ARAC_3.9a_Counter Fraud Update Report.pdf (4 pages)
- ARAC_3.9b_Counter Fraud Investigations Update.pdf (6 pages)

3.10. Information Governance Performance Report

Attached *Head of Information Governance*

- ARAC_3.10_IG Key Performance Report Q1 24-25.pdf (8 pages)

3.11. Standards of Behaviour

Attached *Director of Corporate Governance*

- ARAC_3.11_Board Members Delaration of Interests, Gifts & Hospitality_Sept24.pdf (3 pages)
- ARAC_3.11a_AppA_Board Members Delaration of Interests_Sept24.pdf (3 pages)
- ARAC_3.11b_AppB_Declarations of Gifts & Hospitality_Sept24.pdf (1 pages)
- ARAC_3.11c_AppC_Standards of Behaviour Framework Summary.pdf (3 pages)

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3.12. Welsh Health Circular Tracker

Attached *Director of Corporate Governance*

- ARAC_3.12_Welsh Health Circulars_September_2024.pdf (4 pages)
- ARAC_3.12a_Appendix 1 - Outstanding WHCs and MDs.pdf (6 pages)
- ARAC_3.12b_Appendix 2 - Completed WHCs since last report March 2024.pdf (6 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

There are no items for inclusion in this section

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Committee Annual Work programme

Attached *Director of Corporate Governance*

- ARAC_5.1_ARAC Work Programs 2024 25.pdf (1 pages)

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

5.3. Any Other Urgent Business

5.4. Committee Feedback

Chair

5.5. Date of next meeting:

14 January 2025

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POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 08 OCTOBER 2024
10:00 – 13:00
VIA MICROSOFT TEAMS

AGENDA

Time	Item	Title	Attached /Oral	Presenter
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
	1.3	Minutes from the Previous Meeting held 09 July 2024	Attached	Chair
	1.4	Committee Action Log • ARA/24/16 – On Track • 3 Actions Completed	Attached	Chair
	2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
There are no items for inclusion in this section				
	3	**ITEMS FOR ASSURANCE**		
10.05	3.1	Internal Audit Progress Report 24/25	Attached	Head of Internal Audit
10.15	3.2	Internal Audit Reports: • End of Life Care Services (Reasonable Assurance) • Integrated Performance Framework (Substantial Assurance) • Integrated Plan Development Process (Reasonable Assurance) • Cleaning Standards (Reasonable Assurance)	Attached	Head of Internal Audit
10.30	3.3	External Audit Progress Report	Attached	External Audit
10.50	3.4	Audit report – roles and responsibilities	Presentation	Director of Corporate Governance
11.00	3.5	Audit Recommendation Tracker	Attached	Director of Corporate Governance
11.20	3.6	Board Assurance Framework	Presentation	Director of Corporate Governance

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11.30	3.7	Losses and Special Payments	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
11.40		**COMFORT BREAK 10 minutes**		
11.50	3.8	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
11.55	3.9	Counter Fraud Update	Attached	Head of Local Counter Fraud
12.10	3.10	Information Governance Performance Report	Attached	Head of Information Governance
12.20	3.11	Standards of Behaviour: • Declarations / Register of Interests • Gifts and Hospitality	Attached	Director of Corporate Governance
12.30	3.12	Welsh Health Circular (WHC) Tracker	Attached	Director of Corporate Governance
	4	**ITEMS FOR DISCUSSION**		
		There are no items for inclusion in this section		
	5	**OTHER MATTERS**		
12.40	5.1	Committee Annual Work Programme	Attached	Director of Corporate Governance
12.45	5.2	Items to be Brought to the Attention of the Board and Other Committees	Verbal	Chair
12.50	5.3	Any Other Urgent Business	Verbal	Chair
12.55	5.4	Committee Feedback	Verbal	Chair
13.00	5.5	Date of the Next Meeting: 14 January 2025		

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.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

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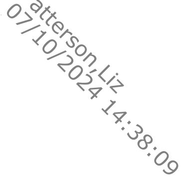
Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.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AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 09 July 2024 VIA MICROSOFT TEAMS

Present:

Rhobert Lewis (RL)	Independent Member (Chair)
Chris Walsh (CW)	Independent Member (Local Authority)
Steve Elliot (SE)	Independent Member (Finance)
Mick Giannasi (MG)	Independent Member (General)

In Attendance:

Hayley Thomas (HT)	Chief Executive Officer (until 11.00)
Pete Hopgood (PH)	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Debra Wood Lawson	Executive Director of People and Culture
Hywel Pullen (HP)	Deputy Director of Finance
Sarah Pritchard (SP)	Head of Financial Services
Helen Bushell (HB)	Director of Corporate Governance/Board Secretary
Bethan Hopkins (BH)	Audit Wales
Mike Jones (MJ)	Internal Audit
Ian Virgil (IV)	Head of Internal Audit
Jayne Gibbon (JG)	Internal Audit
Mathew Evans (ME)	Counter Fraud
Rhys Meadows (RM)	Audit Wales
Helen Grindell (HG)	(Health & Care Research Wales)
Catherine Quarrell (CQ)	(Health & Care Research Wales)

Observers:

Laura Tovey (LT)	Internal Audit
Toboline Mupita (TM)	Observer and Mentee of Vice-Chair
Carl Cooper (CC)	PTHB Chair

Committee Support

Elizabeth Patterson (EP)	Interim Head of Corporate Governance
Fran Carapinha (FC)	Corporate Governance Assurance and Risk Officer

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ARA/24/001	**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/24/002	**DECLARATIONS OF INTEREST** The Committee **ACKNOWLEDGED** that all Executive and Independent Member's remuneration were included in the accounts.
ARA/24/003	**MINUTES OF THE MEETINGS HELD 14 May 2024** The minutes of the meetings held on the 14 May 2024 were reviewed and were **ACCEPTED** as a true and accurate record. • HB confirmed the action on p.8 has been completed and the item added to the Chairs Meeting Agenda.
ARA/24/004	**COMMITTEE ACTION LOG** Two actions **NOTED** as Closed and one action to be kept Open for review: • ARA/24/13 – It was AGREED that the wording is reviewed to include the Health Board's response and if appropriate, transfer this action is transferred to the relevant Committee for assurance. The Committee **RECEIVED** and **NOTED** the Action Log.

ARA/24/005	**ANNUAL REPORT AND ACCOUNTS 2023-24 INCLUDING:**
	• Performance Report
	• the Accountability Report, including:
	  o Corporate Governance Report
	  o Remuneration and Staff Report
	  o Parliamentary Accountability and Audit Report
	• the Financial Statements 2023/24
	• Enquiries of Management and those charged with Governance.
	
	The Committee observed that the report was very similar to last draft presented and suggested the presentation focus mainly on changes.
	
	PH presented the financial statements 2023/24.The Health Board had met the control total with a deficit of just under £12m and remained within the capital resource limit of £6.5m.
	
	HB presented the remainder of the Annual report 2023/24 and highlighted the following points:
	• No significant changes had been made to the Accountability Report since the draft report presented at this meeting in May 2024.
	• The Performance Report has been added to report following review and comments through the Delivery and Performance Committee.
	
	HB acknowledged the review and changes to the Annual Report and Accounts made by the different teams and members that help to formulate and build the accuracy of the report.

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	The Committee made the following observation: • The length of the document and its content required attention and reference to achievements highlighted to the public. • Page 3 of the report be amended from £11,983m to £11.938m. **Action: Director of Corporate Governance/Board Secretary** The Committee: • **NOTED** the contents of the report • **NOTED** the accounts have been subject to a statutory audit by Audit Wales (External Audit) • **RECOMMEND** to the Board at its meeting on 11 July 2024 to approve and sign the Annual Report and Financial Accounts for year ending 31 March 2024 • **NOTED** the responses to enquiries of management and those charged with governance.
ARA/24/006	**AUDIT WALES ISA260 AUDIT REPORT INCLUDING LETTER OF REPRESENTATION** MJ presented the report and highlighted the following updates since the last 2023-24 report was presented to the Committee: • Manager and Engagement Lead Final Review completed. • Audit Opinion – In line with last year's opinion is qualified as the Health Board did not meet its revenue resource limit over the three years to 2023-24. • It was proposed that a substantive report is issued. • There are no uncorrected misstatements or significant issues. • The errors identified in the 2022/23 audit relating to payable and accruals were not found in the testing of the balances or transactions for the year ending 31 March 2024. • The materiality for the current year 2023-24 is confirmed as £4.46m, with some areas showing a lower figure. The Committee commended the good working relationships between the Finance and Audit teams and how they support each other in the preparation of a good Audit and Accounts report. The Committee also noted the improvements reported. The Committee **RECEIVED** and accepted the Letter of Representation.
ARA/24/007	**HEAD OF INTERNAL AUDIT OPINION 2023/24** IV presented the Final Head of Internal Audit Opinion 2023-24 Report. The reported findings were summarised highlighting a few changes from the draft Opinion report presented in May 2024: • Three out of the four audits outstanding on the draft report presented in May 2024, have now been completed to a draft stage and outcomes included in this Head of Internal Opinion report.

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	• The outcome of remaining outstanding audit will inform the 2024/25 Head of Audit Opinion report. • In Summary, 21 individual audits were completed in 2023/24. The outcome of three of those audits demonstrated Substantial Assurance, 16 demonstrated Reasonable Assurance and two demonstrated Limited Assurance. This report has been reflected within the Health Board Annual Report as part of the Annual Governance Statement. The Committee raised the following questions: *How does our overall Reasonable Assurance position compare to other Health Boards?* There is overall Reasonable Assurance opinion across the other organisations with two or three having Limited Assurance opinions, therefore, Powys is in the positive side comparing to other Health Boards. *Is the Audit programme stretching to all areas of the organisation or focusing only on the main central points?* Internal Audit try not to duplicate assurance and focus their work in providing assurance on areas where additional assurance is needed, or the assurance position is not clear and can benefit from review. A more in-depth approach will be considered and will encourage members to advise where help is needed so work can be extended to cover these areas. *Is there a theme identified that could support the organisation progress from Reasonable Assurance to a more Substantial Assurance position?* There is a plan to collect data for trend and themes analysis and develop a database which will enable the identification of key themes and provide feedback on themes and trends. This will be presented at the January Committee and annually thereafter. It is predicted that the feedback on those themes alongside with other outcomes will identify areas needing more focus. The Committee **CONSIDERED** and **NOTED** the Head of Internal Audit Opinion and Annual Report for 2023/24.
ARA/24/08 	**INTERNAL AUDIT PROGRESS REPORT 2024/25 AND FINAL INTERNAL AUDIT 2023/24** IV presented the report which included the initial progress on the 2024/25 work programme and overall view of assurance obtained from the following Audits: • Continuing Health Care – Reasonable Assurance • Patient Experience – Reasonable Assurance • Risk Management and Assurance – Reasonable Assurance

The report provided information regarding the progress of Internal Audit work in accordance with the agreed plan. Following the Head of Internal Audit opinion update, matters highlighted to the Committee relating to the 2023/24 Audit Plan were:

- Three audits completed (Substantive Assurance)
- 16 audits completed (Reasonable Assurance)
- Two audits completed (Limited Assurance)
- One outstanding audit will feed into 2024/25 report.

For the 2024/25 Audit Plan the following update was given:

- 27 audits planned of which:
  - Three are in progress
  - Six are in the planning stage
  - One will be brought forward from 2023/24
  - One will be deferred to 2025/26 (Audit Recommendation Tracking process)

Concern was expressed that audit scheduling was heavily weighted to the later part of the year and requested that reporting to the Committee would be staggered to accommodate the number of audits falling due between January and March.
ACTION: Director of Corporate Governance

a) <u>Continuing Health Care (Reasonable Assurance)</u>
JG presented the report which reviewed the process in place for the assessment, approval, recording and monitoring of Continuing Health Care (CHC) and Funded Nursing Care (FNC) to ensure that care is provided to the required standards with appropriate financial controls in operation.
The report confirmed reasonable assurance with five key matters arising.

Members expressed concern that the management response referred to a lack of capacity to process applications. PH outlined that CHCs had been an area of focus due to financial impact. The National Value and Sustainability Board is expected to issue guidance on resourcing levels for CHC teams. The Investment Benefits Group will scrutinise any business case for additional resource.

Which Committee will track these high level recommendations?
PH advised that a decision on how to track this (via an action for Audit, Risk and Assurance Committee or a transferred action to the Delivery and Performance Committee) would be considered with the Director of Corporate Governance.
Action: Executive Director of Finance, Capital and Support Services and Director of Corporate Governance

b) <u>Patient Experience (Reasonable Assurance)</u>

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	IV presented the report which reviewed the arrangements and processes in place within the Health Board for capturing and utilising patient experience. The report confirmed reasonable assurance with two key matters arising. IV confirmed this report sample tested patient experience in Therapy Services rather than patient experience across all provided and commissioned services. **c) Risk Management and Assurance (Reasonable Assurance)** IV presented the report explaining this audit is undertaken annually. It confirmed reasonable assurance with four key matters arising. *How is the Risk and Assurance Group (RAG), established as part of the Board Assurance Framework developing and maturing?* HB advised that RAG was a Sub Group of the Executive Committee. It had been stood down during the Covid-19 pandemic. Recent appointments meant the reconvened group should again meet regularly. The Committee: • **NOTED** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports. • **APPROVED** the proposed adjustment to the 2024/25 plan.

ARA/24/09	**EXTERNAL AUDIT REPORT 2023/24**
	BH presented the External Audit report 2023/24 and gave a progress update on the following Audits:
	• Accounts Audit (already covered in Item 3.1)
	• Performance Audit:
	    o the Review of Urgent and Emergency Care had been published
	    o the deep dive into Financial Efficiencies was in the draft stage
	    o the Structured Assessment 2023 Deep Dive Efficiencies was in the draft stage
	    o Local work on efficiencies did not take place. The audit fee was refunded
	    o All Wales thematic review of planned care at field work stage
	    o Structure Assessment 2024 at planning stage
	    o Structured Assessment 2024 Deep Dive Investment in Digital Systems at planning stage
	    o Local Work reviewing arrangements for managing agency staff not yet started.
	
	MJ added that since the last meeting of the Committee the Annual Report and Accounts of Charitable Funds had been signed and sent to the Charity Commission.

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	It was reported that the external audit efficiency report had not yet been finalised and the Committee sought to understand the reasons for this. External audit colleagues explained the delay related to the moderation process. It was anticipated this would be presented to the Delivery and Performance Committee in August 2024. The Committee **RECEIVED** the report.
ARA/24/010	**COUNTER FRAUD UPDATE** ME presented the report and advised that the level of activity had been impacted by long term sickness absence with the postholder returning to work in January 2024. The service has continued to receive reports of fraud with no particular pattern emerging, examples included working whilst on sick leave, and contractor fraud. Consideration is being given to strategic governance arrangements for counter fraud services in Wales which would be consulted upon. The Committee **RECEIVED** the report and took **ASSURANCE** that appropriate counter fraud systems are in place.
ARA/24/011	**SINGLE TENDER WAIVER (INCLUDING EXTENSIONS TO CONTRACTS)** The Committee **NOTED** that no Single Tender Waiver requests were made between 1 May 2024 and 30 June 2024.
ARA/24/012	**HOSTED BODY ANNUAL REPORT (HEALTH AND CARE RESEARCH WALES)** DWL introduced the item confirming PTHB as the host body and therefore the important role for this Committee to seek assurance against the hosting agreement on an annual basis. HG gave a presentation on the Hosted Body Annual Report from Health and Care Research Wales (HCRW), a pan-Wales body hosted by the Health Board. The key points highlighted were: • Compliance with Health and Safety, Finance and Workforce: - Risks have been managed in line with Powys Risk Management policy, no risks above 12. - Core budget in place provided by Welsh Government - Performance and Development Reviews, in April showed 70% compliance, mandatory training 90%, absence 3-4%, staff turnover 1.4%. HCRW uses mainly hybrid working arrangements with some accommodation across Wales but the main office in Cardiff. The Hosting Agreement has been in place for some time but not with this team. It was taken over and discussed at the Board in 2023 and then assigned to this Committee. This is the first time the Hosted Body Annual Report has been presented to the Audit Risk and Assurance Committee.

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	The Committee **RECEIVED** the report and took **ASSURANCE** that a hosting agreement is in place, both parties fulfil their roles appropriately and monitoring systems are in place across the year.
ARA/24/013	**CONFIRMATION CLINICAL AUDIT PROGRAMME IN PLACE** HB presented the report on behalf of Kate Wright. A copy of the Audit plan is included in appendix to the report. This Audit report takes a slightly different approach in comparison to Internal and External Audits. A mid-year update and then an annual report is presented to the Patient Experience, Quality and Safety Committee, which includes progress on reports, key actions and lessons learned. The Committee took **ASSURANCE** that the Health Board has in place a Clinical Audit Plan, which is overseen by the Patient Experience, Quality and Safety Committee.
ARA/24/014	**AUDIT RECOMMENDATION TRACKER** HB presented the report providing an overview of the current Audit Recommendations Tracker with the following update on the recommendation status: • 24 Actions completed. • 42 not yet due • 16 outstanding or overdue, with four of those relating to limited or no Assurance. The overall number of recommendations had reduced since the last report and the Committee noted the positive improvement in the last 12 to 14 months. The Committee made some observations regarding the presentation/format layout of the report and process followed to ensure recommendations are monitored in a timely manner: • Graph analysis need to read in conjunction with the relevant narrative or be hyperlinked to the report. • The process needs to give assurance that all recommendations are monitored in a timely manner. The Committee **CONSIDERED** the current position of outstanding audit recommendations and took **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.
ARA/24/015	**COMMITTEE ANNUAL WORK PROGRAMME** The Committee **TOOK ASSURANCE** and **NOTED** the annual work programme. There were no amendments or questions.
ARA/24/016	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES**

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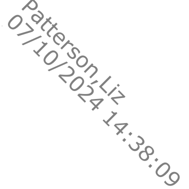
	There were no matters to be brought to the attention of the Board or other committees.
ARA/24/017	**ANY OTHER URGENT BUSINESS** No other urgent business was declared. The Committee noted the retirement of Jane Gibbon (JG), Internal Audit Manager, at the end of August. Committee members acknowledged her contribution to the Health Board and passed on their thanks and best wishes for retirement. JG responded to extend her thanks to the Health Board for the help and engagement during her role as Audit Manager and advised she would be returning to the team in a different role
ARA/24/018	**DATE OF NEXT MEETING** 8 October 2024 at 10:00, Microsoft Teams



Audit and Risk Assurance Committee

RAG Status:

RAG	Description
At risk	Red - action date passed or revised date needed
On track	Yellow - action on target to be completed by agreed/revised date
Completed	Green - action complete
No longer needed	Blue - action to be removed and/or replaced by new action
Transferred	Grey - Transferred to another group

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

Audit and Risk Assurance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW - NONE								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
09-Jul-24	ARA/24/16	Director of Cororate Governance	Internal Audit Progress report 2024-25 and Internal Audit 2023-24	Create a procedure and decide on which Committee (ARAC or D&P) will be responsible for tracking High level Audit recommendations. Add this as an action to the Audit report.	**08.10.2024 update:** PTHB Audit handbook in development which will include this action. Initial presentation also on agenda for 08.10.24 meeting. PTHB handbook due to Committee January 2025 so action remains open	Oct-24		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 10 October 2024)								
09-Jul-24	ARA/24/14	Director of Cororate Governance	Annual Report and Accounts 2023-24	Review the length of the document and its content and make reference to achievements highlighting those to the public. Amend page 3 of the report read £11.938m.	**08.10.2024 update:** Annual report finalised and presented to AGM. AGM presentation included a number of examples of achievements.	Oct-24		Completed
09-Jul-24	ARA/24/15	Director of Cororate Governance	Internal Audit Progress report 2024-25 and Internal Audit 2023-24	Stagger reports going to the committee to accommodate the number of audits falling due between January and March.	**08.10.2024 update:** DCG and Head of Internal Audit have discussed staggering but also presentation. Revised approach agreed and audit handbook in development to clarify roles and responsbilities.	Oct-24		Completed
14-May-24	ARA/24/13	Bethan Hopkins (Audit Wales)	External Audit Report Primary Care	Share any examples of best practice in Wales in calculating a baseline position in relation to investment and resource in primary care	**09.07.2024 update:** All of the Health Boards we have reviewed have experienced challenges in establishing a baseline position which was further compounded by the COVID-19 pandemic. However, some Health Boards are now progressing work in establishing baselines as part of their wider cost improvement programmes and service transformation programmes. The Health Board might want to consider the possibility of adopting a similar approach to establishing its own baseline. **It was AGREED by the Committee - that the wording is reviewed to include the Health Board's response and if appropriate, this action is transferred to the relevant Committee for assurance.** **08.10.24 update -** no examples shared to date, action closed on that basis	Jul-24		Completed

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Agenda item:3.1

Audit, Risk and Assurance Committee	08 October 2024
Subject:	**Internal Audit Progress Report**
Approved and presented by:	Director of Corporate Governance/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.

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **RECIEVE** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
- **NOTE** the adjustment to the 2024/25 plan where management have requested that the audit of Mental Health Care and Treatment Planning be moved from Q2/3 to Q4 as the NHS Executive are currently undertaking a separate audit of Care and Treatment Planning.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	N
2. Provide Early Help and Support	Y
3. Tackle the Big Four	Y
4. Enable Joined up Care	Y
5. Develop Workforce Futures	N
6. Promote Innovative Environments	Y
7. Put Digital First	Y
8. Transforming in Partnership	Y

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EXECUTIVE SUMMARY:
The progress report highlights the conclusions and assurance ratings for audits finalised in the current period. The following audit reports have been finalised since the July 24 meeting of the Committee: • End of Life Care Services (Reasonable Assurance) • Integrated Performance Framework (Substantial Assurance) • Integrated Plan Development Process (Reasonable Assurance) • Cleaning Standards (Reasonable Assurance) The Executive summaries for each of the final reports are included within the progress report, and the full copies of the reports are also included as separate items within the agenda. The progress report also includes details of a proposed adjustment to the timing of the 2024/25 plan. Internal Audit Progress Report 8 th October 2024 Page | 3 Progress with the delivery of the 2024/25 plan is also detailed within Appendix A of the progress report.
HEADING:
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 2024/25 plan was formally approved by the Audit, Risk and Assurance Committee at its March 24 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 details of a proposed adjustment 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.

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Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
October 2024

NWSSP Audit and Assurance Services

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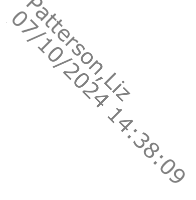
Appendix B	Report Response Times
Appendix C	Key Performance Indicators
Appendix D	Assurance Ratings



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 2024/25 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 2024/25 was agreed by the Audit, Risk & Assurance Committee in March 2024 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

Four audit reports from the 2023/24 plan were not finalised in time for submission to the Audit Committee in May 24, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2023/24.

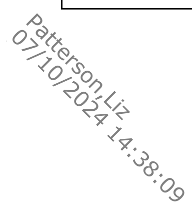
Three of the reports were submitted to the July meeting of the Committee and the remaining one, covering End of Life Care Services, has now been finalised as detailed in the table below.

The audit of the Integrated Performance Framework was also part of the 2023/24 plan but was not completed in time to feed into the 2023/24 annual opinion. As detailed in the table below, the audit has now been finalised and the outcome will inform the 2024/25 opinion.

Two assignments from the 2024/25 plan have also been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

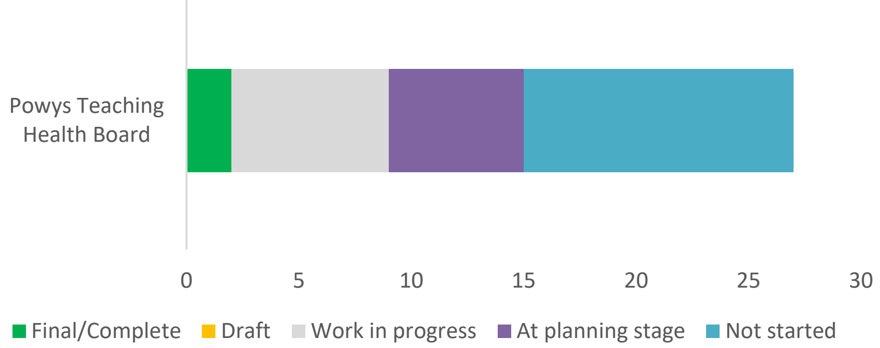
The Executive Summaries from the final reports are provided in Section five. The full reports are included separately within the agenda for information.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
2023/24 Opinion		
End of Life Care Services	Reasonable	
2024/25 Opinion		
Integrated Performance Framework	Substantial	
Integrated Plan Development Process	Reasonable	
Cleaning Standards	Reasonable	



3. Delivery of the 2024/25 Internal Audit Plan

There are a total of 27 reviews included within the 2024/25 Internal Audit Plan, and overall progress to date is summarised below.



The illustration above shows that two audits from the 2024/25 plan have been finalised so far this year.

In addition, there are seven audits that are currently work in progress with a further six 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 A also includes details of the audit from the 2023/24 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2023/24. The outcome from that audit will feed into the 2024/25 Opinion.

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 (KPI).

4. Changes to the 2024/25 Plan

- Management have requested that the audit of Mental Health Care and Treatment Planning be moved from Q2/3 to Q4 as the NHS Executive are currently undertaking a separate audit of Care and Treatment Planning.

5. New Global Internal Audit Standards

In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a

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practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.

We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.

At this point we do not anticipate that there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.

We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

6. Final Report Summaries

5.1 End of Life Care Services

Purpose

The overall objective of the audit was to review the structures and processes in place for the provision of all End of Life Care services to the residents of Powys.

Overview

We have issued reasonable assurance for this audit.

The matters requiring management attention include:

- Reviewing the establishment for the individual localities to ensure an equitable service is provided to Powys residents.
- Review current reporting arrangements for End of Life Care Services with a view to enhancing the information that is being reported both within and outside the Directorate.

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

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

	Objectives	Assurance
1	End of Life Care Services are appropriately structured.	Reasonable
2	Services are appropriately managed	Reasonable
3	There are clear documented pathways	Substantial
4	Regular and accurate monitoring	Limited

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	End of Life Care Services provision	1, 2	Operation	Medium
4	Monitoring and Reporting	4	Design	High

5.2 Integrated Performance Framework

Purpose

The overall objective of this audit was to review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.

Overview

We have issued substantial assurance on this area noting the current good practice in place as follows:

- There is an approved and well-designed Integrated Performance Framework;
- The governance arrangement in place is appropriate;
- Data published within the Integrated Performance Report is effectively validated;
- There is a schedule in place for data submission and report completion; and
- Actions are in place for underperforming measures.

We identified no matters for reporting in our review.

Report Opinion

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	

Assurance summary[1]

	Objectives	Assurance
1	The Framework is appropriately designed, linked to the Health Board's IMTP objectives and NHS Wales Performance Framework	Substantial
2	Appropriate governance arrangements and management processes are in place	Substantial
3	Robust systems and processes are in place to capture and validate the data required to produce the Integrated Performance Report	Substantial
4	The Integrated Performance Report is completed within required timescales	Substantial
5	Appropriate actions are agreed and taken forward to address performance issues identified	Substantial

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

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5.3 Integrated Plan Development Process

Purpose

The overall objective of the audit was to review the processes and assumptions used for developing the 2024/2027 Integrated Plan and Annual Delivery Plan with a focus on the assessment of financial plans.

Overview

Following our review we have provided a reasonable assurance opinion overall which includes the following matters arising:

- The Health Board's statutory requirement to set a balanced budget had not been met; and
- Sufficiently detailed plans backing the savings requirement had not been provided at the point the plan was submitted to Welsh Government (WG).

We have provided Limited Assurance for objective 2b as the financial requirement to produce a balanced plan was not met. However, as noted within sections 2.5 and 2.6 of the report, we acknowledge that the plan did adequately address delivery of the key ministerial priorities.

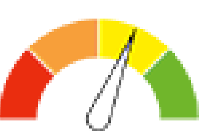
Except for the recommendations above, the overall planning process e.g. its cadence and governance, adequately meets the audit objectives. All the statutory documentation was completed in compliance with the WG guidelines/framework and delivered on time.

Following the WG rejection of the original plan. The Health Board submitted a revised version on 30 May 2024, and are currently in negotiations with the WG to agree a way forward.

It is important to note that our assurance rating relates to the specific objectives of this audit, as detailed within the adjacent Assurance Summary table.

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	The Health Board's planning process is aligned to the NHS Wales Planning Framework.	Substantial
2a	The Plan included clear and measurable targets and actions towards delivery of ministerial priorities.	Substantial
2b	The Plan adhered to the statutory duty to breakeven.	Limited
2c	Savings plans were fully developed at the point of submission to Welsh Government.	Reasonable
3	Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the Integrated Plan is subject to scrutiny and review prior to submission to Welsh Government.	Substantial

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Statutory requirement for the three-year 2024/2027 plan to break-even was not met.	2b	Design	High
2	Plans not identified to fully deliver the financial savings requirement.	2c	Design	Medium

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5.4 Cleaning Standards

Purpose

The overall objective of the audit was to review the processes and controls in place to ensure compliance with cleaning standards in place within the Health Board.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Clarification of the Board's delegation of responsibilities for cleaning standards.
- The introduction of assurance mechanisms for physical areas belonging to the Health Board where cleaning services are provided by an external body.
- The reporting arrangements for Cleaning Standards at Board level need to be reviewed and formalised.

Other recommendations principally relate to the centralisation of training records and minor updates to documentation.

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	Governance Arrangements	Reasonable
2	Policies and Procedures	Substantial
3	Awareness and Training	Substantial
4	Monitoring and Reporting	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Governance Arrangements	1	Operation	Medium
3	Services Provided by Third Parties	2	Design	Medium
6	Reporting Arrangements	4	Operation	Medium

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ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2023/24 Plan								
Integrated Performance Framework	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.		Planning, Performance and Commissioning			Final Report	Substantial	October
2024/25 Plan								
Integrated Plan Development Process	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	13	Planning, Performance and Commissioning	1		Final Report	Reasonable	October
Cleaning Standards	Review of processes and controls in place to ensure compliance with national cleaning standards.	21	Finance, Capital and Support Services	1		Final Report	Reasonable	October
Core Financial Systems – Treasury Management	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	15	Finance, Capital and Support Services	2		Work in Progress		January
Patient Flow / Discharge Management	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.	6	Primary Care, Community and Mental Health	1		Work in Progress		January
Board & Committee Structure / Effectiveness	Evaluate the Health Board's Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	2	Corporate Governance / Board Secretary	2		Work in Progress		January

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Energy Management	Determine the adequacy of and operational compliance with, the established systems for the management and control of energy consumption within the Health Board and will also take account of other supporting regulatory and procedural requirements as appropriate.	25	Finance, Capital and Support Services	2		Work in Progress		January
Capital Systems	A review of the arrangements in place for the selection and award of advisers and contractors at health board projects; to include the use of local, regional, and national framework arrangements, adequacy of contractual arrangements applied etc.	26	Finance, Capital and Support Services	2		Work in Progress		January
Local Primary Mental Health Support Services	Review of how the Local Primary Mental Health Support Services are structured, managed and delivered.	8	Primary Care, Community and Mental Health	2/3		Planning		January
Staff Retention	Review and assessment of the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.	11	People and Culture	2/3		Work in Progress		January
Additional Learning Needs Legislation	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	19	Nursing, Quality, Women and Family Health	2/3		Final Brief Issued		January
Deprivation of Liberties Safeguards (DoLS)	Review of the arrangements for ensuring compliance with DoLS requirements including role of Best Interest Assessors. Will need to consider potential scope of this audit further.	10	Nursing, Quality, Women and Family Health	3		Work in Progress		January
Community Cardiology	Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.	24	Primary Care, Community and Mental Health	3		Draft Brief Issued		January

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Follow-up: Information Governance	Follow-up of 23/24 Limited Assurance report.	17	Corporate Governance / Board Secretary	3		Planning		January
Primary Care - Ophthalmology Contract	Review of the processes for managing the ophthalmology contract and monitoring and reporting performance.	16	Primary Care, Community and Mental Health	3				March
Contract Management	To provide assurance that the Health Board has appropriate contract management arrangements in place. Review of Health Board arrangements along with the interaction and assurance received from NWSSP Procurement Services.	14	Finance, Capital and Support Services	3		Planning		March
Records Management	Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.	18	Corporate Governance / Board Secretary	3		Final Brief Issued		March
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Following on from the 23/24 audit of the corporate level arrangements.	23	Public Health	3				March
Cancer Services	A review of Cancer Services included for the second half of the plan. Scope could cover the Cancer Tracking Service or Harm Review Process, to be confirmed later in the year.	5	Medical	3/4				March
Medicines Management	Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing. Exact scope of audit to be agreed.	4	Medical Director	4				March
Partnership Governance Framework	Review of the development and implementation of the Framework.	12	Planning, Performance and Commissioning	4				March

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
			/ Corporate Governance					
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	22	Finance, Capital and Support Services	4				March
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance / Board Secretary	4				May
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.	7	Primary Care, Community and Mental Health	~~2/3~~	4			May
Quality & Safety Governance (Duty of Quality)	Review of the implementation and operation of the new arrangements around quality and governance structures and floor to Board reporting. Potentially include a review of the Integrated Quality Report.	9	Nursing, Quality, Women and Family Health	4				May
Medical Devices - Mattresses	Review of actions taken to address previous incidents that have occurred within the Health Board around mattresses. Provide assurance on whether revised processes and controls are being effectively applied.	2o	Finance, Capital and Support Services	4				May
Capital Project	To assess the THB's processes, procedures and operational management of the delivery of either the proposed new multi-agency wellbeing campus in Newtown or the Llandrindod Wells redevelopment programme.	27	Finance, Capital and Support Services	TBC				TBC
Estates Condition Follow-up	Follow-up of 23/24 Limited Assurance report.	28	Finance, Capital and Support Services	TBC				TBC

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Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reviews removed from the plan								
Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	3	Corporate Governance / Board Secretary	The Director of Corporate Governance / Board Secretary identified that a new system for management of policies had been approved for implementation during 2024/25, so the audit was deferred to 2025/26 to provide assurance on the new system. Approved by July 24 ARAC.				

REPORT RESPONSE TIMES

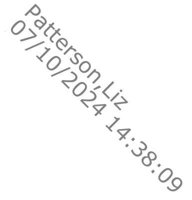
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Integrated Performance Framework	Substantial	Final	29/07/24	19/08/24	15/08/24	15/08/24	G
Cleaning Standards	Reasonable	Final	20/09/24	11/10/24	27/09/24	30/09/24	G
Integrated Plan Development Process	Reasonable	Final	22/08/24	13/09/24	30/09/24	30/09/24	R

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	May 2024	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	R	60% 3 from 5	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	A	67% 2 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	67% 2 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 3 from 3	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

Rating	Description
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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End of Life Care Services Final Internal Audit Report

September 2024

Powys Teaching Health Board

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Review reference:	PTHB-2324-13
Report status:	Final
Fieldwork commencement:	7 May 2024
Fieldwork completion:	7 June 2024
Debrief meeting:	25 June 2024
Draft report issued:	18 July 2024
Management response received:	13 August 2024
Final report issued:	15 August 2024
Auditors:	Ian Virgill, Head of Internal Audit Jayne Gibbon, Audit Manager
Executive sign-off:	Kate Wright, Executive Medical Director
Distribution:	Louise Hymers, Macmillan Lead Nurse for Cancer and Palliative Care
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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Executive Summary

Purpose

The overall objective of the audit was to review the structures and processes in place for the provision of all End of Life Care services to the residents of Powys.

Overview

We have issued reasonable assurance for this audit.

The matters requiring management attention include:

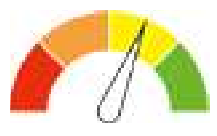
- Reviewing the establishment for the individual localities to ensure an equitable service is provided to Powys residents.
- Review current reporting arrangements for End of Life Care Services with a view to enhancing the information that is being reported both within and outside the Directorate.

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

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

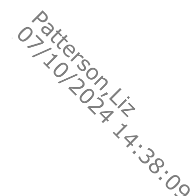
Assurance summary[1]

	Objectives	Assurance
1	End of Life Care Services are appropriately structured.	Reasonable
2	Services are appropriately managed	Reasonable
3	There are clear documented pathways	Substantial
4	Regular and accurate monitoring	Limited

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	End of Life Care Services provision	1, 2	Operation	Medium
4	Monitoring and Reporting	4	Design	High



1. Introduction

1.1 The review of End of Life Care Services was completed in line with the Powys Teaching Health Board's (the 'Health Board') 2023/24 Internal Audit Plan.

1.2 End of life care is support for people who are in the last months or years of their life and should help the individual to live as well as possible until they die and to die with dignity. End of life care can be received at home, in a care home, hospice or in hospital, depending on individual needs and preference.

1.3 The provision of End of Life Care services to the residents of Powys is delivered through a variety of services including the Health Board's Specialist Palliative Care Team (the 'Team'), with sites in North, Mid and South Powys, GP's, District Nurses, community hospitals and care homes.

1.4 The potential risks considered during this audit were as follows:

- Powys residents are unable to access end of life care services; and
- Issues with the provision of services are not identified, escalated or addressed.

1.5 The lead Executive for this review is the Executive Medical Director.

2. Detailed Audit Findings

Objective 1: End of Life Care services are appropriately structured to allow for equitable access for residents across Powys.

2.1 The Specialist Palliative Care Team is structured across three geographical areas of North, Mid and South Powys. The Team is managed by the Macmillan Lead Nurse for Cancer and Palliative Care and supported by two End of Life GP Facilitators, each providing 2 sessions per week.

2.2 The operating hours for In Hours service provision by the Team is the same across the three localities, with each providing services Monday to Friday 8.30am to 4.30pm.

2.3 The staff structures (establishments) vary between each locality due to the differences in the geography and demographics of each locality. We have been informed that there has not been a review of each locality's staffing establishment for some time. **(Matter Arising 1)**

2.4 The out of hours service provision is provided by the Health Board's District Nursing service as well as providers such as neighboring health boards and third sector organisations commissioned by the Health Board.

Conclusion:

2.5 Whilst the hours of service provision are consistent for each locality, we note the establishments for each locality vary and these establishments have not been reviewed for some time. We have allocated **Reasonable Assurance** for this objective.

Objective 2: The services are appropriately managed, resourced and funded to allow for effective and sustainable on-going provision.

2.6 We note that whilst there is one cost centre for managing the budgets for the In Hours service provided by the Team, the funded establishment is divided into the three localities. As noted in paragraph 2.2 above the 'identified' establishment for each locality was based on the respective geography and demographics.

2.7 As part of our fieldwork, we met with each locality lead to discuss the level of resources available and if they felt it was suitable to meet the needs of the service. The following areas of concerns were raised at these meetings:

- The Team is receiving an increase in the number of patient referrals;
- More complex cases are being referred to the Team, e.g. patients with co-morbidities;
- Current staffing levels allocated are struggling with number of patients being referred;
- Insufficient level of medical cover provision; and
- Access issues to out of hours service is impacting on in hours service.

2.8 In light of the concerns raised by the locality leads a review of the establishment for the Team needs to be undertaken. **(Matter Arising 1)**

2.9 We also note the Duty Nurse 'pilot' that is currently being undertaken within the North Locality team. The purpose of the role is to triage patients referred to the team and allocate to staff caseloads. The role also 'takes' all ad hoc calls made to the team and undertakes follow up calls. We are advised that the pilot has led to better caseload management for the team within the locality.

Conclusion:

2.10 Whilst there are identified establishments in place for each locality, as a result of the concerns that have been raised a review of these establishments should be undertaken. We have allocated **Reasonable Assurance** for this objective.

Objective 3: There are clear, documented pathways in place for Powys residents to either access or be referred into the services, including out of hours provision, and these are publicised and made available to all relevant individuals.

2.11 The Specialist Palliative Care Operational Policy provides details on the referral process to the 'Service' including that referrals should be made via the All Wales Specialist Palliative Care Referral form.

2.12 Each locality has a Patient Information Leaflet that will be given to the patient and their family/carer when they have their first contact with the team after the referral. The leaflet provides information on the Specialist Palliative Care Team, contacts for the In Hours and Out of Hours service and details of the service that the team provides.

2.13 At the first contact with the patient and their family/carer, the wishes of the patient is discussed with the patient with regards to the service provision. This will then be discussed and reviewed at each subsequent contact and care plan/service provision updated accordingly. The team will endeavour to meet the wishes of the patients but there may be occasions where that may not be possible due to the patient's condition, level of support and lack of hospital/hospice provision.

2.14 There are a number of policies and procedures in place within the Health Board that detail the processes to be followed for referring patients to the End of Life Care services and also the management of the patients.

2.15 Our review of the policies and procedures in place highlighted that two of the policies were overdue for review and that whilst one procedure noted that it would be reviewed every three months we were unable to determine if such reviews had taken place. **(Matter Arising 2)**

2.16 The policies and procedures are accessible to all staff via the Health Board's Policies and Procedures page on its Intranet (Sharepoint).

Conclusion:

2.17 There are clear pathways for accessing services and several policies and procedures are in place that document the services provided and are accessible to all staff. We have allocated **Substantial Assurance** for this objective,

Objective 4: Robust arrangements are in place for regular and accurate monitoring and recording of the delivery of services and performance is reported to appropriate management, groups and committees within the Health Board.

2.18 On a monthly basis the Service Lead will provide updates to the Community Services Manager (CSM) under the following headings:

- Caseload;
- Waiting Times;
- Successes; and
- Concerns for Escalation/Awareness.

2.19 The above information is then converted into a slide by the CSM and then submitted to the bi-monthly meetings of the Community Services Group Operational and Quality & Safety meetings. Whilst this information is reviewed within the Directorate there is currently no information regarding the service reported to any Health Board Committee or included as part of the Health Board's Integrated Performance Report (from 24/25 known as the Integrated Quality and Performance and Quality Report). **(Matter Arising 3)**

2.20 Furthermore, we note that the Team collates a plethora of data regarding the service it provides that whilst it is reviewed within the Team it does not appear to be elsewhere within the Directorate. **(Matter Arising 3)**

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2.21 We note that there are currently two groups in place within the Health Board whose purpose is to provide strategic direction for the delivery of end of life services. The groups are 'End of Life Care Strategy Group' and 'Last Year of Life Group'. We have been advised that going forward it is the intention to merge the two groups. We are not aware of any performance information being reported to these groups.

Conclusion:

2.22 Whilst some information regarding service activity is reported within the Directorate no information is reported at Committee level. Additionally, the team records data that is not reviewed outside of the service. We have allocated **Limited Assurance** for this objective.

8/15

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Appendix A: Management Action Plan

Matter Arising 1: EOL End of Life Care Services provision (Operation)	**Impact**
We note that whilst there are no separate budgets for the three localities there are agreed establishments in place for each locality that are based on the demographics and geography of each locality which we are advised have not been reviewed for some time. As part of our fieldwork meetings were held with each locality lead to discuss the current establishment and whether they feel it is sufficient to meet the current needs of the Powys residents. The following concerns were brought to our attention which the leads felt were impacting on the service they are able to provide: • The teams were all experiencing an increase in the number of patients being referred into the service that impacted on staff caseloads; • The number of complex cases being referred has increased, e.g. patients with co-morbidities; • The level of medical provision is insufficient to meet current demands; and • Access issues to out of hours service is impacting on the 'In – Hours' service. We were informed that the North Locality is currently piloting a 'Duty Nurse' post within the team. The role involves receiving all referrals into the team, triaging the calls and then allocating to a team member's caseload. The role will take ad hoc phone calls and also undertake planned follow up calls. Initial feedback on this pilot has led to improved caseload management for the team members.	Powys residents are unable to access end of life care services.

Recommendations		**Priority**
1	Management should undertake a review of the current service needs and provision for end of life services as soon as possible. A review of the pilot being undertaken within the North Locality should also be undertaken with a view to implementing across all localities. Whilst the focus of the audit has been on the In-Hours service provision, due to the concerns raised by staff it is recommended that the provision of Out of Hours Service is also reviewed.	**Medium**

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Agreed Management Action		Target Date	Responsible Officer
1	**In Hours** We will work on reporting processes to understand service activity, demand and capacity, and then work to review the establishment of the Specialist Palliative Care Team, as part of sustainability planning within the health board. Review of pilot – triage nurse The Specialist Palliative Care Team will continue to review the pilot of a triage nurse currently being undertaken in North Powys, and share the learning with the Mid and South localities, identifying how this model could support service delivery – N.B. the establishment of staff in the Mid and South is currently lower, therefore the model may not be effectively embedded in these areas until the wider team establishment is reviewed, the option of a Pan-Powys triage approach will be explored. **Out of Hours** Provision of commissioned services provided via hospice partners across Wales is currently being reviewed by the Joint Commissioning Committee, this process commenced in April 2024; with all health boards across Wales being asked to pause any new hospice commissioning agreements. Prior to this change, PTHB was in the process of reviewing the hospice commissioned services to ensure they were fit for purpose and met the needs of our palliative and end of life patients. We are anticipating regular updates from the JCC, and will fully participate in the review process, if required we will build on the JCC work to ensure the needs of our residents at end of life are met.	Q3-Q4 2024/2025 Await update from JCC	Lousie Hymers Macmillan Lead Nurse for Cancer and Palliative Care

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Matter Arising 2: Policies & Procedures (Operation)	**Impact**
Our review of the guidance and policies in place relating to end of life services noted that a number of documents were overdue for review as follows: • PTHB/GNP 001 Verification of Death by a Health Care Professional Policy – the policy was due for review in April 2023; and • PTHB/GNP 081 Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals – the procedure was due for review in January 2024. We also noted that the Procedure PTHB/GNP 075 Administration of as-needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales (The CARiAD Package) states that the procedure would be reviewed every 3 months. There is no indication on the current version of this document that these reviews have/are taking place. (We do acknowledge that this procedure is an All Wales document).	Guidance in place for staff may be out of date.

Recommendations		**Priority**
2	Management should ensure that those documents overdue for review are reviewed and approved by an appropriate forum as soon as possible. Once approved the updated documents need to be made accessible to all health board staff. For the remaining procedure (PTHB/GNP 075) management need to determine if reviews have taken place and ensure latest version of the document is available to all health board staff.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	**PTHB/GNP 001 – Verification of Death by a Health Care Professional Policy**	Q3 2024/2025	Louis Hymers Macmillan Lead Nurse for Cancer and Palliative Care

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	We will link with accountable executive (Executive Director of Nursing) to ensure the document is updated **PTHB/GNP 081 - Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals** Link with accountable executive (Executive Director of Nursing) to ensure the document is updated **PTHB/GNP 075 - Administration of as-needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales (The CARiAD Package)** Continue to liaise with team in BCUHB who are currently updating the policy – once available to progress through PTHB policy processes	 Q3 2024/2025 Q3 2024/2025	

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Matter Arising 3: Reporting (Design)	**Impact**
From our audit fieldwork we note that information regarding the number of patients accessing the service and also any concerns / issues affecting the service are reported at the Community Services Group Operational and Community Services Group Quality & Safety bi-monthly meetings, however at the current time we note that no information regarding the service activity is currently reported to any Health Board Committees or included within the Health Board's Integrated Performance Report. As part of our fieldwork we noted that the Service records a vast amount of data that currently is not being routinely reported/shared outside of the Service. The information that is currently recorded includes: • Review of acuity of patient caseload on a weekly basis • Number of new referrals (monthly) • Number of discharges (monthly) • Number of deaths (monthly) • Preferred place of death audit (PPD) We were also advised that due to the nature of the service they provide the service also has patients that are re referred into them due to the nature of their illness so data regarding the reasons for re referral and frequency could also be recorded.	Issues with the provision of services are not identified, escalated or addressed.

Recommendations		**Priority**
3	Management should review the data that is currently being collated by the Service in order to consider which information should be included as part of the Health Board's Integrated Quality and Performance Report. We acknowledge that not all data collated can be included with the Health Board's Integrated Performance Report and so management should also review and consider any additional information that should be reported within the Community Services Group.	**High**

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Agreed Management Action		Target Date	Responsible Officer
3	We will review the reporting measures of the Specialist Palliative Care Team within the Community Services Group and identify an appropriate reporting mechanism, in line with the recommendations within this report. We will also work with our commissioning team to ensure that systems related to the reporting of commissioned palliative / end of life services are robust	Q3 2024/2025	Louise Hymers Macmillan Lead Nurse for Cancer and Palliative Care

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.
	Unsatisfactory 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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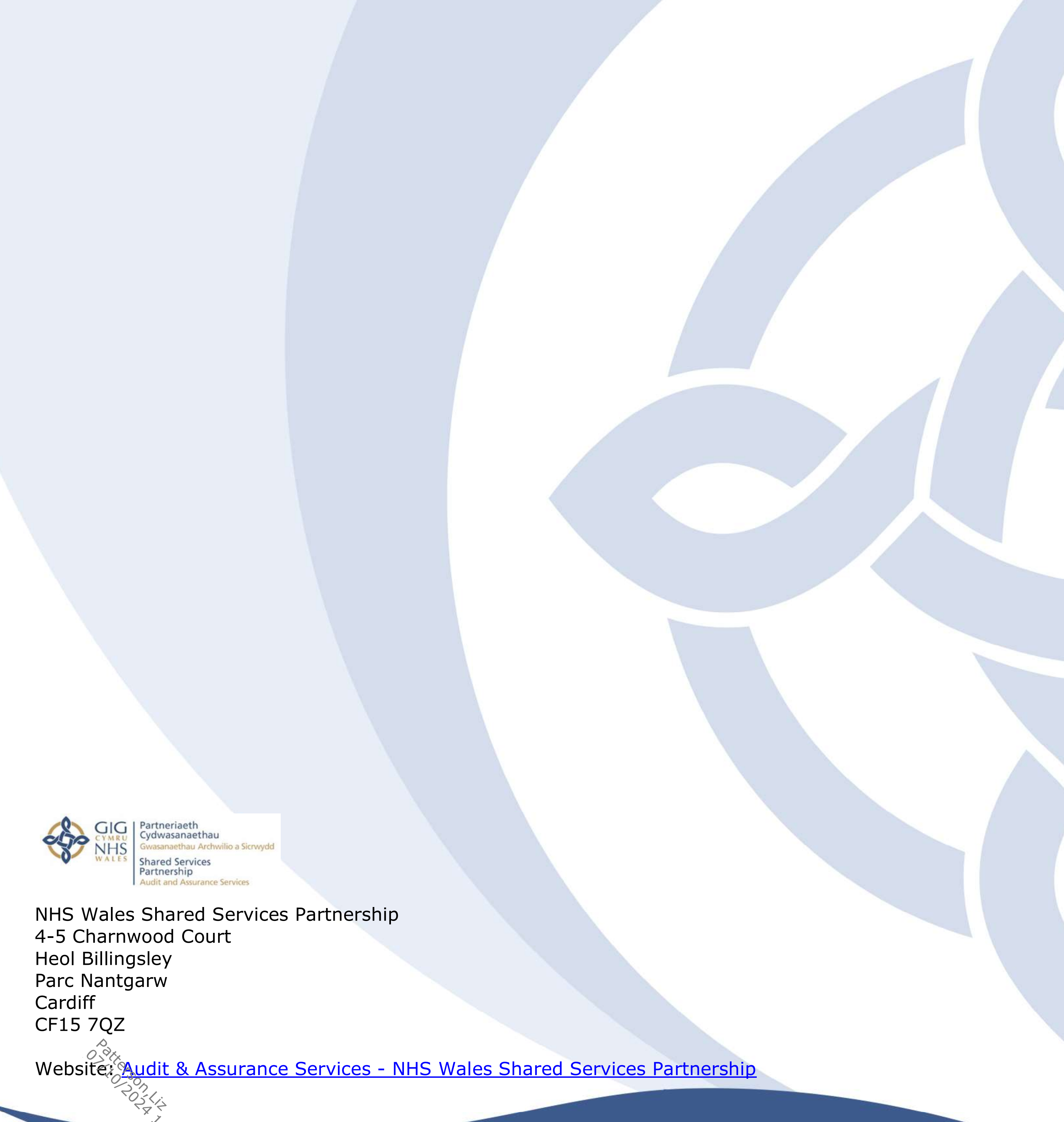

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Integrated Performance Framework

Final Internal Audit Report

August 2024

Powys Teaching Health Board

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Draft report issued:	29th July 2024
Final report issued:	15th August, 2024
Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Jayne Gibbon, Audit Manager Ian Virgill, Head of Internal Audit
Executive sign-off:	Stephen Powell, Executive Director of Performance and Commissioning
Distribution:	Chris Moss, Assistant Director of Performance and Commissioning Simon McLellan, Head of Performance
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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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This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The overall objective of this audit was to review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.

Overview

We have issued substantial assurance on this area noting the current good practice in place as follows:

- There is an approved and well-designed Integrated Performance Framework;
- The governance arrangement in place is appropriate;
- Data published within the Integrated Performance Report is effectively validated;
- There is a schedule in place for data submission and report completion; and
- Actions are in place for underperforming measures.

We identified no matters for reporting in our review.

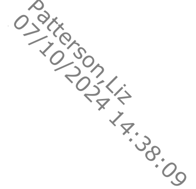
Report Opinion

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	

Assurance summary[1]

	Objectives	Assurance
1	The Framework is appropriately designed, linked to the Health Board's IMTP objectives and NHS Wales Performance Framework	Substantial
2	Appropriate governance arrangements and management processes are in place	Substantial
3	Robust systems and processes are in place to capture and validate the data required to produce the Integrated Performance Report	Substantial
4	The Integrated Performance Report is completed within required timescales	Substantial
5	Appropriate actions are agreed and taken forward to address performance issues identified	Substantial

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



1. Introduction

1.1 The review of the Integrated Performance Framework was completed in line with the Powys Teaching Health Board's (the 'Health Board') 2023/24 Internal Audit Plan.

1.2 Effective performance reporting is integral to the Health Board's overall management and assurance arrangements. Performance reporting should focus on continuous improvement and delivering improved outcomes, highlighting when action is required to meet expected outcomes aligned to overall strategy and ministerial priorities.

1.3 The Health Board has developed an Integrated Performance Framework (the 'Framework') to provide challenge, support and scrutiny of both provider and commissioned services, with the aim of driving improvement in Health Board performance and health outcomes for those patients that Powys is responsible for. The Framework was formally approved by the Board in September 2022, for implementation from April 2023.

1.4 Performance against the Framework is reported to the Delivery & Performance Committee, and onwards to the Board, via an Integrated Performance Report which provides the latest available performance update against the 2023/24 NHS Wales Performance Framework.

1.5 We previously audited the Health Board's Performance Management and Reporting arrangements in 2022/23 and provided a Substantial assurance report in June 2023.

1.6 The lead Executive for this review is the Executive Director of Performance and Commissioning.

1.7 The potential risks considered for this review were as follows:

- Services provided to Powys residents do not meet performance measures due to ineffective monitoring and management of performance;
- Inaccurate and / or incomplete performance information; and
- Underperforming areas are not effectively identified and / or addressed.

2. Detailed Audit Findings

Objective 1: The Framework is appropriately designed to allow for the effective management and improvement of performance across all provider and commissioned services, linked to the Health Board's IMTP objectives and NHS Wales Performance Framework.

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2.1 There is an approved Integrated Performance Framework in place that details the arrangements in place within the Health Board for the management and improvement of performance. The Integrated Performance Framework 2022/23 - 2025/26 was approved at the September 2022 Health Board Meeting. In April

2024, it was reviewed, updated and renamed, 'the Integrated Quality & Performance Framework'.

2.2 The framework outlines information on the following key areas:

- all services/areas within the Health Board that the Framework applies to including Commissioned and Provided Services;
- the principles that underpin the Framework;
- summary of the roles and responsibilities for managing and improving performance ranging from the Board to all Health Board staff;
- Performance measures to be reported; and
- Processes in place for the reporting, review, escalation and assurance of performance measures.

Conclusion:

2.3 There is an approved and up to date Integrated Performance Framework in place that sets out the arrangements in place for the management of performance. We have provided **Substantial Assurance** for this objective.

Objective 2: Appropriate governance arrangements and management processes are in place to ensure the effective implementation and on-going utilisation of the Framework throughout the Health Board.

2.4 The Integrated Performance Framework sets out roles and responsibilities of the Executive and Operational Leads. It also sets out the reporting and monitoring arrangements.

2.5 For those months that the full Integrated Performance Report is not produced the Performance Department (the 'Department') will instead produce a Performance Dashboard which is available to all key staff and will be shared on request. The dashboard will also be referenced when the Director of Performance & Commissioning updates the Executive Committee on any concerns/challenges on specific performance measures.

2.6 We were able to confirm that the Integrated Performance Report was submitted for discussion to all Delivery & Performance Committee and Health Board meetings that took place in the financial year 23/24 in accordance with the meetings Workplans.

2.7 Directorate Performance Review meetings take place twice a year, a standard set of slides are utilised which each Directorate has to complete for review and discussion at these meeting.

Conclusion:

2.8 The governance arrangements for Performance Management are clearly identified within the Framework. Regular updates on Performance are submitted to appropriate Health Board forums. We have provided **Substantial Assurance** for this objective.

Objective 3: Robust systems and processes are in place to capture and validate the data required to populate the Framework and produce the Integrated Performance Report.

2.9 There is a procedure in place that outlines the process to be undertaken by the Department for validating all data before it is populated in the Integrated Performance Report and reported within the Health Board and submitted to Welsh Government.

2.10 Data is sense checked by the Performance Team against previous performance and what is published by Welsh Government. If an anomaly is detected this is queried with the data owner.

2.11 Our testing of Performance Targets sampled from the four Quadruple Aims (QA), as reported in the Month 11 2023/24 Integrated Performance Report, verified that the reported figures were accurate and could be reconciled to their data source.

Conclusion:

2.12 There are robust systems and processes in place to produce the Integrated Performance Report. The samples reviewed evidenced that the data published within the Integrated Performance Report was accurate. We have provided **Substantial Assurance** for this objective.

Objective 4: The Integrated Performance Report is completed within required timescales to allow for timely reporting to the relevant governance forums

2.13 The Integrated Performance Report was presented at all the relevant committees. Refer to paragraph 2.6.

2.14 There is a timetable which highlights the submission deadlines for the Executive Committee, Delivery & Performance Committee and Health Board where the integrated performance report is presented. It also included the submission deadline to the Executive Committee. This includes the date of submission to the corporate team and the processing times for key leads.

2.15 We reviewed the compilation process for the Integrated Performance Report and found performance data is published on a monthly basis via SharePoint, whether or not a report is intended to be compiled in that period. There is a Standard Operating Procedure in place that outlines the process for producing/populating the Integrated Performance Report.

Conclusion:

2.1 There are arrangements in place to ensure the timely compilation of the Integrated Performance Report for reporting to the relevant governance forum. We have provided **Substantial Assurance** for this objective.

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Objective 5: Appropriate actions are agreed and taken forward to address performance issues identified through the Framework and within the Integrated Performance Report.

2.16 The Delivery & Performance Committee and Board meetings between October 2023 and May 2024 were reviewed to understand how underperforming measures were managed in terms of monitoring and reporting.

2.17 Underperforming performance measures are categorised either as an exception or an escalation. Progress on underperformance is monitored and reported within the areas responsible for the performance measure.

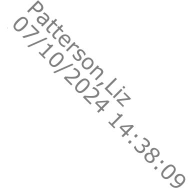
2.18 In cases where an escalation is noted a separate Remedial Action Plan (RAP) is developed and reviewed monthly. Where exceptions are noted, actions undertaken are highlighted within the Integrated Performance Report.

2.19 A sample of two performance measures that were below target were selected for review to understand the process undertaken to address any issues regarding performance. The measures were Quadruple Aim 1, Measure 3- Percentage of children up to date with scheduled vaccinations by age 5 and Quadruple Aim 2, Measure 26- % of children <18 waiting 14 weeks or less for a specified Allied Health Professional.

2.20 The review of the two selected performance measures, (specifically on how the Delivery & Performance Committee & Board address underperformance), evidenced that appropriate actions are agreed and taken forward to address performance issues identified.

Conclusion:

2.21 Appropriate actions are undertaken to address underperformance of measures identified within the Integrated Performance Report. We have provided **Substantial Assurance** for this objective.



Appendix A: 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.
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Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
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* Unless a more appropriate timescale is identified/agreed at the assignment.

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Integrated Plan Development Process

Final Internal Audit Report

September 2024

Powys Teaching Health Board

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Final report issued:	30 September 2024
Auditors:	Ian Virgill, Head of Internal Audit Jayne Gibbon Audit Manager Carl Mason, Principal Auditor
Executive sign-off:	Stephen Powell, Executive Director of Planning Performance and Commissioning.
Distribution:	Samantha Ruthven – Hill Assistant Director of Planning.
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

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Executive Summary

Purpose

The overall objective of the audit was to review the processes and assumptions used for developing the 2024/2027 Integrated Plan and Annual Delivery Plan with a focus on the assessment of financial plans.

Overview

Following our review we have provided a reasonable assurance opinion overall which includes the following matters arising:

- The Health Board's statutory requirement to set a balanced budget had not been met; and
- Sufficiently detailed plans backing the savings requirement had not been provided at the point the plan was submitted to Welsh Government (WG).

We have provided Limited Assurance for objective 2b as the financial requirement to produce a balanced plan was not met. However, as noted within sections 2.5 and 2.6 of the report, we acknowledge that the plan did adequately address delivery of the key ministerial priorities.

Except for the recommendations above, the overall planning process e.g. its cadence and governance, adequately meets the audit objectives. All the statutory documentation was completed in compliance with the WG guidelines/framework and delivered on time.

Following the WG rejection of the original plan. The Health Board submitted a revised version on 30 May 2024, and are currently in negotiations with the WG to agree a way forward.

It is important to note that our assurance rating relates to the specific objectives of this audit, as detailed within the adjacent Assurance Summary table.

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	The Health Board's planning process is aligned to the NHS Wales Planning Framework.	Substantial
2a	The Plan included clear and measurable targets and actions towards delivery of ministerial priorities.	Substantial
2b	The Plan adhered to the statutory duty to breakeven.	Limited
2c	Savings plans were fully developed at the point of submission to Welsh Government.	Reasonable
3	Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the Integrated Plan is subject to scrutiny and review prior to submission to Welsh Government.	Substantial

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Statutory requirement for the three-year 2024/2027 plan to break-even was not met.	2b	Design	High
2	Plans not identified to fully deliver the financial savings requirement.	2c	Design	Medium

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1. Introduction

1.1 The review of the Integrated Planning Development Process was completed in line with the Powys Teaching Health Board's (the 'Health Board') 2024/25 Internal Audit Plan.

1.2 The Health Board approved a five-year Integrated Plan for April 2024 to March 2029 at its meeting held on 20th March 2024. Within the cover report submitted to the Board it was recognised that the plan set out a planned deficit of £24.9m for 2024/25. The final plan was submitted to Welsh Government on 28th March and feedback has been provided notifying of additional requirements.

1.3 The Annual Delivery Plan for 2024-2025, which is the first year of the Delivery of the five-year Integrated Plan 2024-29 and is fully aligned to the submission of the PTHB plan was approved by the Health Board on 22 May 2024. It was noted that changes may be required to the Annual Delivery Plan to reflect requirements issued by Welsh Government after receipt of the five-year Integrated Plan.

1.4 The Executive Director of Planning, Performance and Commissioning is the lead for this review.

2. Detailed Audit Findings

Objective 1: The Health Board's planning process is aligned to the NHS Wales Planning Framework.

2.1 The Welsh Government's (WG) 2024/2025 IMTP planning framework requirements issued on 18 December 2023 stipulates a three-year planning horizon. Our review noted that the Health Board has developed an annual rolling series of plans covering both five-and ten-year horizons. To meet the WG framework requirement, the Board approved the submission of their full five-year plan 2024/2029 at its meeting on 20 March 2024. This was then submitted to the WG on 28 March 2024 in compliance with the reporting timeline.

2.2 Our review covered the first three-years of the five-year plan, and we were able to confirm that the Health Board's planning process was adequately aligned to the NHS Wales Planning Framework.

2.3 The 28 March 2024 submission included all the statutory additional documentation:

- The three County Cluster plans.
- Minimum Data Sets (MDS).
- Five Ministerial Priority templates.
- The Six Goals for Urgent and Emergency Care.

Conclusion:

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2.4 Our review established that the Health Board had implemented and executed a planning process that adequately aligned to the WG 2024/2025 Framework and Guidance. We have provided **Substantial Assurance** for this objective.

Objective 2: The development of the Integrated/Annual Delivery Plans include clear and measurable targets and actions towards delivery of ministerial priorities.

Objective 2a: The Plan included clear and measurable targets and actions towards delivery of ministerial priorities.

2.5 The Ministerial Priority List published as part of the NHS Wales Planning Framework 2024-27 included:

- Enhanced Community Care: Reducing delayed pathways to care;
- Primary Care: Improving access and shifting resources into primary and community;
- Urgent Emergency Care: Delivering the 6 goals programme;
- Planned Care: reducing the longest waits; and
- Mental Health: Delivery of national programme.

2.6 Our review of the planning process noted that each of the above priorities had been adequately addressed. Standard template questionnaires have been completed for each priority that included milestones, planned outcomes, priority areas, overarching metrics, risk/mitigation, critical enablers e.g. digital, and opportunities.

Conclusion:

2.7 Our review established that the development of the plan included clear measured targets and actions toward delivering the ministerial priorities. We have provided **Substantial Assurance** for this objective.

Objective 2b: The Plan adhered to the statutory duty to breakeven.

2.8 The framework also stipulated that:

- In compliance with their statutory duty the three-year plan should break-even;
- demonstrate continued progress in reducing reliance on high-cost agency staff; and
- increase administrative efficiency, to enable a reduction in administrative and management costs as a proportion of the spend base.

2.9 Our review of the above established that the plan complied with the reduction in agency spending (38.30%) and improved administrative efficiency (0.19%). However, the plan did not meet the overall requirement to produce a break-even plan in accordance with the WG Planning Guidance and the Health Board's Standing Financial Instructions (SFI) 5A and 5C(b). **(Matters Arising 1)**

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Conclusion:

2.10 Due to the Health Board being unable to comply with the required break-even position we have provided **Limited Assurance** for this objective.

Objective 2c: Savings plans were fully developed at the point of submission to Welsh Government.

2.11 The MDS submitted to the WG on 28 March 2024 provided details on projected savings plans totalling £7.9m, with each savings project risk assessed. Our review noted that £3.47m of the savings plans were identified as red schemes or pipeline and planning developments with a higher level of delivery risk. The MDS resubmitted on 30 May 2024, increased the savings total to £9.9m, with £6.9m red schemes or pipeline. **(Matters Arising 2)**

Conclusion:

2.12 The required savings plans were not fully developed at the point the MDS were submitted to WG. We have provided **Reasonable Assurance** for this objective.

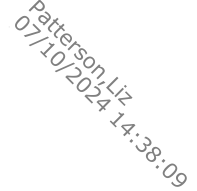
Objective 3: Appropriate governance arrangements are in place, which provide effective oversight of the planning process, ensuring the Integrated Plan is subject to scrutiny and review prior to submission to Welsh Government.

2.13 The annual planning cycle was initiated in September and facilitated by the Director/ Assistant Director of Planning. The cycle consisted of eight workshops with a target completion date of March 2024 to comply with the WG planning guidance. All the Heads of the operational directorates e.g. Finance and Public Health attended the workshops and Provided input from their designated areas of authority as part of an ongoing collaborative planning approach.

2.14 Output from the workshops was available to the Health Board's Executives and Independent Members via a dedicated share-point folder. PowerPoint presentations were also produced following each of the eight workshops reflecting the ongoing discussions. The last workshop took place on 14 March 2024 and formed the basis for the final draft of the Integrated Plan presented to and approved by the Board on the 20 March 2024.

Conclusion:

2.15 Our review established that there were appropriate governance arrangements in place, which provided effective oversight of the planning process, ensuring the Integrated Plan was subject to scrutiny and review prior to submission to the WG on 28 March 2024. We have provided **Substantial Assurance** for this objective.



Appendix A: Management Action Plan

Matter Arising 1: Statutory requirement for the three-year 2024/2027 plan to break-even was not met. (Design)	**Impact**
The Health Board did not submit a three-year balanced integrated plan for 2024/2027 to the WG, and was therefore not in compliance with WG Planning Framework Guidance 2024/2025 and the Board's Standard Financial Instructions (SFI) 5A and 5C(b). The original Board proposal was not acceptable to the WG. A revised plan has now been submitted (31 May 2024) reducing the deficit. The revision still does not meet the break-even requirement and the Board is awaiting the WG response.	Potential risk of: • WG imposing a budget cap to meet the break-even position. • Significant impact on the Board's ability to meet it operational commitments. • Reputational damage. • Negative impact on staff and other service providers.

	Recommendations	**Priority**
1	Management need to develop a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Health Board's plan is not in balance. (Board SFI 5C.C)	**High**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	Agreed. The Health Board is developing a Routemap to Sustainability, which is intended to fulfil this requirement. It is anticipated that the proposals it contains will need to be subject to Engagement, and then Consultation, with the public, staff and other stakeholders. Develop proposals for a sustainable recovery plan.	March 2025	Executive Director of People and Culture

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<table>
<tr><th colspan="3">Matter Arising 2: Plans not identified to fully deliver the financial savings requirement (Design)</th><th>Impact</th></tr>
<tr><td colspan="3">The Minimum Data Set (MDS) submitted to the WG on 28 March 2024 provided details on projected savings plans that total £7.9m, with each savings project risk assessed. Our review noted that £3.47m were identified as Red schemes or pipeline and planning assumptions with a higher level of delivery risk. The MDS resubmitted on 30 May 2024, increased the savings total to £9.95m, with £6.9m red schemes or pipeline. This included an additional £2m of stretch savings which the Health Board aims to deliver in response to WG further challenge. These were included within red schemes or pipeline as they were brand new and not included within the original plan.

The Health Board acknowledged the higher delivery risk associated with the red and pipeline schemes but were sufficiently confidence to build them in as valid savings schemes.

We note that at Month 4 the Health Board's actual assessment of schemes against the £9.9m savings requirement is that there are no current red ratings against those schemes.</td><td>Potential risk of:
• Forecast financial outturn for 2024/25 is not achieved.
• Savings plans are not identified until later in the year which increases pressure on delivery.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>2</td><td colspan="2">Management should ensure that future plans identify robust schemes to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>2</td><td>Agreed. Each year, the Health Board strives to identify and develop a full set of robust schemes to support the delivery of the savings target within the Financial Plan. This is a collective activity, led by the Executive Director of Finance, Capital and Support Services, which all the Executive team contribute to.</td><td>March 2025</td><td>Executive Director of Finance, Capital and Support Services and Deputy Chief Executive</td></tr>
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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.
	Unsatisfactory 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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Cleaning Standards
Final Internal Audit Report

August 2024

Powys Teaching Health Board

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Final report issued:	30th September 2024
Auditors:	Ian Virgill, Head of Internal Audit Jayne Gibbon, Internal Audit Manager Warren Alexander, Principal Internal Auditor
Executive sign-off:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Distribution:	Jason Crowl, Assistant Director – Support Services Duncan Crawley, Service Improvement 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 Chartered Institute of Public Finance & Accountancy in April 2023.

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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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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Executive Summary

Purpose

The overall objective of the audit was to review the processes and controls in place to ensure compliance with cleaning standards in place within the Health Board.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Clarification of the Board's delegation of responsibilities for cleaning standards.
- The introduction of assurance mechanisms for physical areas belonging to the Health Board where cleaning services are provided by an external body.
- The reporting arrangements for Cleaning Standards at Board level need to be reviewed and formalised.

Other recommendations principally relate to the centralisation of training records and minor updates to documentation.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

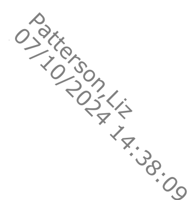
Assurance summary[1]

	Objectives	Assurance
1	Governance Arrangements	Reasonable
2	Policies and Procedures	Substantial
3	Awareness and Training	Substantial
4	Monitoring and Reporting	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Governance Arrangements	1	Operation	Medium
3	Services Provided by Third Parties	2	Design	Medium
6	Reporting Arrangements	4	Operation	Medium



1. Introduction

1.1 The review of Cleaning Standards was completed in line with the 2024/25 Internal Audit Plan for the Powys Teaching Health Board (the 'Health Board' or 'PTHB').

1.2 The Health Board recognises that different areas of their hospitals represent varying levels of risk in terms of infection transmission i.e. areas, where higher intrusive clinical activities take place such as Theatres, Birth Centres, Dentistry, Podiatry etc. The greater the risk allocation, the greater the standards of cleanliness required, and these are acquired by increased intensity and frequency of cleaning.

1.3 The Support Services Department has the lead responsibility for maintaining the hygiene and cleanliness of the Health Board's environment, including clinical, non-clinical and public areas. Cleaning responsibilities also fall to other staff groups within the Health Board such as nurses.

1.4 The Executive Director of Finance, Capital & Support Services / Deputy Chief Executive is the lead for this review.

2. Detailed Audit Findings

Objective 1: There are appropriate governance arrangements and lines of accountability in place for cleaning standards.

2.1 The Model Standing Orders (Sch. 4 - Board Committee Arrangements) adopted by The Health Board in July 2021 specify that the full range of PTHB responsibilities in relation to Support Services has been delegated by the Board to the Delivery and Performance (D&P) Committee. The Terms of Reference of this Committee are incorporated into the Model Standing Orders document. The D&P Committee's TOR were reviewed in February 2024, but the D&P Committee's Annual Report to the Board which was included in the papers of February 2024 and the Board Meeting Papers of May 2024 specifies that the Committee's TOR were agreed in September 2021. **(Matter Arising 1).**

2.2 The 'Director of Workforce and OD' is listed as an attendee in the D&P Committee's TOR. This role was redefined as 'Executive Director of People and Culture' as a result of the changes to the Executive structure detailed in the Board meeting of 22nd May. Further changes included the reassignment of Support Services to the Executive Director of Finance, Capital and Support Services, formerly the Executive Director of Finance, IT & Information Services. The D&P Committee's TOR have not been updated since these changes have taken place and therefore contain outdated information with respect to its listed attendees. **(Matter Arising 1).**

2.3 During the course of the audit, we were advised that that some relevant information was reported to the Patient Experience, Quality and Safety (PEQS) Committee, but no reference is made to Support Services or Cleaning Standards in the Committee's TOR.

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2.4 The PEQS Committee TOR specify that 'the scope of the Committee extends to the full range of PTHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services'. Reference to matters relating to cleaning standards appear limited to one clause which states that 'the Committee will seek assurance that arrangements for the provision of high quality, safe and effective healthcare are sufficient, effective and robust, including: the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings'. None of the Officers listed as regular attendees of the Committee are directly involved in the management of Support Services.

2.5 It would therefore appear that effectively, reporting in relation to cleaning standards is currently divided between the D&P and the PEQS Committees, but there is insufficient clarity with respect to areas of responsibility. **(Matter Arising 1).**

2.6 The Support Services senior management team hold management meetings on an approximately monthly basis where issues in relation to cleaning standards are discussed. Attendees include the Assistant Director of Support Services, the Quality and Compliance Manager, the Support Services Managers, Business Support Manager and Quality Improvement Manager.

2.7 Further meetings take place, with a similar frequency, where the Support Services Managers cascade information to the Support Services Coordinators. There are also formal meetings including the Managers, Coordinators and Supervisors held on an ad-hoc basis, and Monthly Cleaning Assurance Subgroup Meetings involving Support Services Managers.

Conclusion:

2.8 Governance and reporting arrangements in relation to cleaning standards have been established but have not been clearly defined. Roles and responsibilities in relation to the Management and Supervision of Cleaning Standards have been clearly defined and are appropriately documented, although some updates to documentation are required. This objective has therefore been given a **Reasonable** assurance rating.

Objective 2: There are policies and procedures in place that set out the required cleaning standards across the Health Board.

2.9 The Health Board's Policy in relation to cleaning standards is documented in the Environmental Cleanliness Standards Operating Procedure document (the 'Procedure'), which was formulated with reference to the Welsh Government's National Standards for Cleaning in NHS Wales (2009), the English NHS's National Standards of Healthcare Cleanliness (2021), and UK Government guidance relating to infection prevention and control. The Procedure was issued in March 2022 following authorisation by the then Director of Environment and is scheduled for review in January 2025. **(Matter Arising 2).**

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2.10 The Procedure covers a broad scope and provides comprehensive information relating to various aspects of cleaning standards. The contents include:

- Details of the roles and responsibilities which relate to the maintenance of cleaning standards in the Health Board;
- Definitions of risk categories for functional areas;
- General cleaning and disinfection principles;
- Cleaning intensity definitions;
- Infection prevention and control information;
- Method statement guidance;
- General and occupation specific health and safety considerations; and
- Information in relation to audit procedures.

2.11 A link to the Procedure document has been included in the Environmental Cleanliness section of the Support Services page within the PTHB intranet, which also includes further information and guidance with respect to cleaning standards. Hard copies of the Procedure are filed in Support Services Offices and more specific guidance documents relating to each area or room are available in each functional area.

2.12 Some specialist activities such as high-level cleaning are undertaken by contractors or other departments and may not be directly managed by Support Services. As such, individuals providing services under these circumstances may not be aware of the specifications of the Procedure. In such instances, the Support Services Managers, Coordinators or Supervisors provide oversight and ensure that the requirements of the Procedure are met, arranging for remedial actions or additional cleaning to be undertaken by Health Board cleaning staff where required.

2.13 One area, physically situated within a hospital belonging to the Health Board was highlighted as being outside the remit of Support Services with respect to cleaning duties, which are instead undertaken by a third-party contractor. No assurance activities in respect of this area appear to have been undertaken by the Health Board. **(Matter Arising 3).**

Conclusion:

2.14 A comprehensive Cleaning Standards Procedure is in place, up to date and subject to a regular review schedule whereupon appropriate consideration is given to statutory requirements. Operational guidance is available and readily accessible to all relevant staff. Some risks have been highlighted in relation to the cleaning activities of parties other than PTHB Support Services. This objective has been given a **Substantial** assurance rating.

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Objective 3: There is staff awareness and promotion of the cleaning standards and staff have undertaken / received appropriate levels of training.

2.15 The requirements of the Procedure are incorporated into staff induction programmes, which are also tailored to each individual post. Changes are cascaded via management meetings to Support Services Coordinators and Supervisors, who ensure cleaning staff receive relevant updates. Toolbox talks or training sessions are arranged where required.

2.16 Introductory training requirements are standardised. A comprehensive induction programme is in place which covers subjects such as Infection Prevention and Control and Health and Safety. There are also more specific guidance documents which break down the cleaning requirements for each room as appropriate. Cleaning staff are expected to refer to these documents when they are initially training or when they are required to clean an area that is unfamiliar to them.

2.17 New starters are also paired with experienced staff to benefit from their guidance until they achieve competence. At this stage, any additional training requirements are identified, and remedial actions are implemented. This process is generally led by the Support Services Supervisors.

2.18 Training sign-off sheets in relation to local training protocols are maintained for each staff member. They include dates and confirmation signatures from the training recipient, these are retained by the Supervisors. As part of the audit, visits were made to three of the Health Board's hospitals and a sample of training records were examined at each site. All were completed, signed and dated appropriately.

2.19 Hard copies of ESR training records are also held. ESR training compliance is monitored by the Support Services Managers and Coordinators and is managed by the Support Services Coordinators and Supervisors.

2.20 Whilst training compliance was observed to be effectively monitored, it was noted that data in relation to local training activities was not collated centrally. **(Matter Arising 4).**

2.21 The training programme is updated on an ad-hoc basis in response to changes in operational requirements. These updates are usually directed by Support Services management or instigated by Infection Prevention and Control.

Conclusion:

2.22 The requirements of the Cleaning Standards Procedure were observed to be effectively communicated to staff by various means. Training requirements are updated in response to a range of factors and satisfactory training records are maintained. ESR records were retained within the ESR system and local training records were held in the Support Services offices. This objective has therefore been given a **Substantial** assurance rating.

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Objective 4: There are appropriate monitoring and reporting arrangements in place for cleaning standards.

2.23 Cleaning staff are briefed at the commencement of their shifts by the Support Services Supervisor, notice boards are used to post cleaning schedules detailing

individual rooms to be cleaned by designated staff. Regular liaison with ward/area staff enables cleaning resources to be targeted more effectively and with greater efficiency.

2.24 There is also active collaboration between cleaning staff and other Support Services staff, as well as other departments such as Infection Prevention and Control and Estates. In cases where staffing resources are limited, areas are prioritised in accordance with their risk category, meaning some lower risk areas are subject to less frequent cleaning. These areas are monitored by the Support Services Supervisor and scheduled for remedial cleaning at the earliest opportunity when staffing levels are restored. General oversight in this area is provided by the Support Services Coordinators and Managers.

2.25 At an operational level, cleaning standards are monitored by means of a prescribed programme of regular audits, which are undertaken by the Support Services Supervisors. Audit frequency is determined based on the risk rating of the functional area. Periodic management audits which are administered via the same system are also undertaken, either by the Support Services Coordinators or Managers.

2.26 As part of our fieldwork, visits were made to three of the Health Board's hospitals. A sample of cleaning programmes relating to specific rooms was selected and examined. Generally, schedules were found to have been completed correctly, and notes were recorded where appropriate. One instance where some minor omissions had occurred was identified at Llandrindod Wells War Memorial Hospital. (**Matter Arising 5)**

2.27 Minutes of the Support Services Management meetings (as detailed in sections 2.6 and 2.7 above) covering a six-month period, were examined. All meetings were found to be well attended and various matters relating to Cleaning Standards were observed to have been addressed.

2.28 The D&P Committee Terms of Reference were agreed by the Health Board in September 2021. Recent D&P Committee minutes were examined, all meetings were found to be quorate and were generally well attended. Some input from Support Services has been documented but there was limited evidence of reporting or scrutiny explicitly relating to cleaning standards during the period examined. (**Matter Arising 6).**

2.29 The Terms of Reference for the PEQS Committee specify that 'the scope of the Committee extends to the full range of PTHB responsibilities' and as such, some reporting of matters directly in relation to cleaning standards and the work of support services takes place.

2.30 Recent PEQS Committee Minutes were examined, and it was found that whilst Support Services do not participate or have a direct input into these meetings, some matters relating to their responsibilities in respect of maintaining cleaning standards are reported to the committee in conjunction with Infection Prevention and Control considerations.

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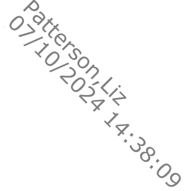
2.31 Currently, some information relating to cleaning standards is reported variously to the D&P Committee, the PEQS Committee, or directly to the Board. It would also appear that in the absence of established reporting procedures, overall, insufficient information has been reported to:

- Enable the board or its nominated committee(s) to provide informed oversight in relation to cleaning standards; and
- Provide adequate assurances that cleaning standards are being maintained and that the performance of Support Services in this area is satisfactory.

2.32 Whilst it can be observed that some matters relating to cleaning standards are reported to the D&P and PEQS Committees, and to the Board directly, the level of information provided does not appear to be sufficient or detailed enough to permit effective oversight. **(Matter Arising 6).**

Conclusion:

2.33 Monitoring of cleaning standards involves direct oversight by Support Services Supervisors, who ensure cleaning schedules are complete. A comprehensive audit programme is also in place, and results were found to be monitored appropriately. Overall, very little information appears to have been reported to the Health Board and its delegated committees. Reports do not appear to have been sufficiently detailed to enable adequate assurances to be provided in respect of cleaning standards. This objective has therefore been given a **Reasonable** assurance rating.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Appendix A: Management Action Plan

Matter Arising 1: Governance Arrangements (Operation)	**Impact**
Whilst it was found that governance arrangements had been established and documented in relation to Support Services, there remains a lack of clarity with regard to the reporting framework specifically in respect of cleaning standards Our review of the TOR for the D&P and PEQS Committees identified references to previous Executive Directors, and neither document was found to contain specific information with respect to the delegation of responsibilities in relation to cleaning standards. Whilst Support Services is mentioned in the D&P Committee TOR, there is no explicit reference to cleaning standards, and it would also appear that in practice, as much information relating to cleaning standards is reported to the PEQS Committee or directly to the Board. Although the TOR documents of the D&P Committee were reviewed in February 2024, the document has not been updated to reflect this, and amendments have not been made in response to the recent Executive reorganisation. A review of the PEQS Committee's TOR appeared to be ongoing at the time of audit.	Potential risk of: The Board is unaware of issues concerning cleaning standards.

Recommendations		**Priority**
1.1	A review of governance and reporting arrangements in relation to Support Services and cleaning standards should be undertaken to ensure there is a clear line of reporting and escalation upto Board level. The revised reporting arrangements should then be formally approved at the appropriate Board/Committee meeting.	**Medium**
1.2	Upon completion of the review, the TOR documents of any relevant committees should be updated to reflect the revised reporting arrangements that are decided upon and also reflect the current Executive arrangements.	

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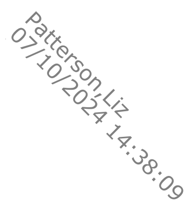
Agreed Management Action		Target Date	Responsible Officer
1.1	Review the reporting arrangements from the Directorate to the Board level for Cleaning Standards.	1/4/2025	Head of Support Services
1.2	Update the TOR for the respective groups to ensure they reflect the need to receive and report on cleaning standards.	1/4/2025	Head of Support Services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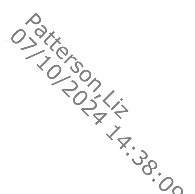
Matter Arising 2: Updates to the Cleaning Standards Policy (Operation)			**Impact**
The recent changes to the Executive structure have resulted in references becoming outdated in some documents, this is evident in the Environmental Cleanliness Standards Operational Procedure where the Director of Environment is specified as being responsible for Support Services.			Potential risk of: Premises are not appropriately cleaned or maintained leading to staff or patient harm and associated financial and reputational implications.
Recommendations			**Priority**
2	Management should ensure that the Environmental Cleanliness Standards Operating Procedure and any other relevant documentation is reviewed and updated to reflect the current Executive arrangements.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	Update the Environmental Cleanliness Standards Operating Procedure to reflect current Executive arrangements.	1/12/2024	Assistant Director Support Services



Matter Arising 3: Services Provided by Third Parties (Design)			**Impact**
The Renal Unit at Llandrindod Wells War Memorial Hospital is operated in partnership with University Hospital Birmingham. Whilst this unit is situated within the premises of Llandrindod Wells War Memorial Hospital, separate cleaning arrangements are in place which do not involve PTHB Support Services staff. We were advised that no assurance mechanisms are currently in place to ensure that the cleaning arrangements meet the cleaning standards that have been implemented by PTHB. This introduces the risk that the cleaning standards maintained within the unit are not consistent with those of PTHB, and therefore assurances cannot be provided in this area.			Potential risk of: Premises are not appropriately cleaned or maintained leading to staff or patient harm and associated financial and reputational implications.
Recommendations			**Priority**
3	Management should ensure that any areas/services within the Health Board where cleaning services are provided by an external body that mechanisms are implemented to provide assurance of compliance with the Health Board's cleaning standards.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Support Services to support the quality monitoring of the renal contract for the hospital.	1/4/2025	Head of Support Services

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Matter Arising 4: Training Records (Operation)			Impact
The Support Services department was found to have adequately prioritised staff training in relation to cleaning standards, with specific focus being evident with regard to inductions for new starters and compliance with mandatory training requirements. Whilst comprehensive training records were maintained, it was noted that the documentation relating to local training exercises was retained within local Support Services offices and the information relating to these exercises was not collated centrally. It would be beneficial in terms of completeness in documenting the work of Support Services staff, and also in terms of providing assurances to the Health Board that training requirements are being met, if mechanisms were in place to ensure more detailed management information relating to local training exercises was available.			Potential risk of: Premises are not appropriately cleaned or maintained leading to staff or patient harm and associated financial and reputational implications.
Recommendations			**Priority**
4	Management should consider collating local training records to produce a central training record. This should be periodically reviewed to ensure compliance rates are maintained at a satisfactory level, and to enable any anomalies to be identified and addressed at the earliest opportunity.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	A sharepoint folder system to be established which is managed centrally and accessible by local managers to upload training compliance records.	1/4/2025	Head of Support Services

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Matter Arising 5: Cleaning Schedules (Operation)			**Impact**
A total of 24 Cleaning Schedules were examined during the course of the audit. Each of these specifies a list of cleaning tasks that are to be undertaken in the room or area to which the schedule relates. Cleaning staff are required to place a 'tick' next to the tasks as they complete them, and then sign the schedule to confirm that the programme of work has been completed. Two of the Cleaning Schedules had been signed, but ticks had not been placed against the listed activities. This results in an increased risk that operational staff fail to complete individual tasks listed in the Cleaning Schedules and compromises the Health Board's ability to demonstrate that adherence to cleaning specifications has always been maintained.			Potential risk of: Premises are not appropriately cleaned or maintained leading to staff or patient harm and associated financial and reputational implications.
Recommendations			**Priority**
5	Management should ensure that Operational staff are reminded that Cleaning Schedules must always be fully completed.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	Maintain quality assurance reports around audit compliance at the Support Services Quality Assurance Meeting.	1/4/2025	Head of Support Services

Matter Arising 6: Reporting (Operation)			**Impact**
Our review of six recent meetings of the Delivery & Performance Committee found that apart from brief comments within the IMTP progress reports no updates regarding Cleaning Standards have been reported. However, a review of six recent meetings of the PEQS committee found that some information relating to cleaning standards was reported as part of Infection, Prevention & Control Updates. It would be expected that some matters relating to key areas such as performance monitoring, recruitment and retention, updates to policies / procedures and the impact of Executive changes would be reported to and discussed at the Health Board's nominated committee(s) in the context of support services and cleaning standards, but this does not appear to have been the case. Improvements in this area would increase the Health Board's ability to provide effective oversight in the area of cleaning standards and enhance the ability of management to provide assurances with respect to the effective operation of the Support Services department.			Potential risk of: The Board is unaware of issues concerning cleaning standards.
Recommendations			**Priority**
6	Management should review all information that is currently recorded and available in respect of Cleaning Standards. Discussions should then take place as to what Committee this information should be reported to and the frequency of the updates.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6	1. Create a reporting dashboard which brings together what is currently recorded and available in respect to cleaning standards. 2. Confirm which Management Meeting and Executive Committee this dashboard is reported to.	1/4/2025	Head of Support 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.
	Unsatisfactory 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: September 2024

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.

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

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Audit, Risk and Assurance Committee Update

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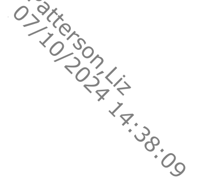


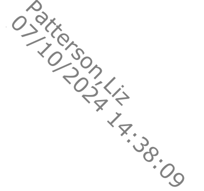
About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board. We presented our most recent Audit Plan to the committee in May 2024.

2 We also provide additional information on:

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

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

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

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date of completion
Audit of the 2023-24 Charitable Funds Financial Statements	Director of Finance, Information, and IT	Audit of the financial statements to inform the audit opinion.	Not yet started	January 2025
Audit of the 2024-25 Accountability Report and Financial Statements	Director of Finance, Information, and IT	Statutory audit of the financial statements to inform the audit opinion.	Not yet started. Planning due to commence December 2024.	Opinion prior to 30 June 2025

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Performance audit update

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

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Urgent and Emergency Care	Medical Director	This work will examine different aspects of the urgent and emergency care system and will include analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working.	Blog and data tool published in April 2022	
		The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1).	Part 1 - Fieldwork complete and report drafting now underway.	January 2025
		We also plan to review progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Part 2 – Fieldwork underway	January 2025

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 Deep Dive - Financial Efficiencies	Director of Finance, Information, and IT	This audit is to assure the Auditor General that the NHS body has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities, in the context of the financial climate.	Issued in draft	October 2024
Local Work 2023	NA	We had intended on focusing on the Health Board's arrangements for managing financial efficiencies. However, this was overtaken by the change in the audit plan which introduced the Structured Assessment Deep Dive - Financial Efficiencies across all NHS bodies. We have therefore refunded the relevant part of the audit fee related to this local work.	NA	NA
All-Wales thematic review of planned care	Interim Director of Operations	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and	Fieldwork underway	January 2025

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Use of the additional Welsh Government financial allocations to improve waiting lists.		
Structured Assessment 2024 - Core	Director of Corporate Governance/Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork underway	January 2025
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Director of Finance, Information and IT	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Planning	TBC

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local work 2024 – review of arrangements for managing agency staff	Director of Nursing	This work will review the Health Board's arrangements to manage agency staff use within community hospital wards. The exact scope of the work is still to be developed.	Not yet started	TBC

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Other relevant publications

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

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

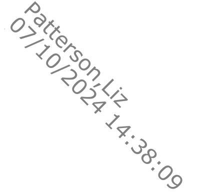
Title	Publication Date
Community Pharmacy Data Matching Pilot | Audit Wales	May 2024
Affordable Housing	September 2024

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update.

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
Annual Report and Accounts 2023-24	August 2024



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

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Management response form

Report title: Review of Cost Savings Arrangements

Completion date: 01/10/2024

Document reference: 4417A2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potential costs and savings that will arise through its introduction in order to place its finances on a more sustainable footing.	Agreed – The Health Board has established a programme of work around future sustainability with programme and workstream structure: - **'Task force' in place to examine three areas:** • the future model (building on existing work) • options and decisions around when to achieve financial breakeven. • new opportunities based on analysis of data and benchmarking. Identified timeline in place with initial engagement planned for 24/25.	In place and as per timelines identified.	Director of Improvement and Transformation

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R2	The Health Board should make greater use of Getting it Right First-Time (GIRFT) reviews that directly apply to the Health Board as a further source of potential intelligence to inform its savings identification arrangements.	Agreed – To note The Health Board has been fully engaged and implemented GIRFT principles for its provider services where relevant and is working with other providers for commissioned services therefore already actioned.	In place and complete (note this is a continuous process).	Executive Director of Planning, Performance and Commissioning
R3	The Health Board should set challenging but realistic targets for its individual savings schemes. It should also develop robust but achievable action plans for its schemes accompanied by suitable delivery arrangements to ensure they achieve their intended aims.	Agreed and noted - Targets set are challenging and realistic and under constant review, a pipeline of opportunity is encouraged across all services to mitigate any shortfalls. A comprehensive process is already in place to deliver against plans as identified.	In place and complete (note this is a continuous process).	Director of Finance, Capital, Estates and Support Services.
R4	The Health Board should broaden its assessment of capacity beyond its Finance Team to identify and develop plans to	Agreed – The Health Board has advertised an additional finance role to support the business partner team in this area. The wider operational capacity will be kept under review to ensure the	Complete with ongoing review.	Director of Transformation and Improvement

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	address any shortfall or gaps in available resource in its wider operational teams.	newly established Director of Transformation and Improvement (with associated team and portfolio established) is supporting delivery in operational areas as needed.		with support of Chief Executive and Executive Directors
R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the Accelerated Sustainable Model.	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery.	In place and complete (note this is a continuous process).	Director of Transformation and Improvement with support of Chief Executive and Executive Directors
R6	The Health Board should clearly identify savings delivery risks, and mitigating actions within in its corporate and operational risk management arrangements.	Agreed, already included in the risk register but this has been updated and enhanced.	In place and complete (note this is a continuous process).	Director of Corporate Governance

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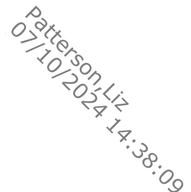
Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	The Health Board needs to prioritise how best to turn its red savings schemes into recurrent green and amber schemes that have a realistic chance of delivering the identified savings.	Agreed and ongoing action.	In place and complete (note this is a continuous process).	Director of Finance, Capital, Estates and Support Services.
R8	The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach with the aim of placing less reliance on non-recurrent savings.	Agreed and ongoing action.	In place and complete (note this is a continuous process).	Director of Finance, Capital, Estates and Support Services.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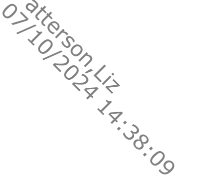
Review of Cost Savings Arrangements – Powys Teaching Health Board

Audit year: 2023

Date issued: August 2024

Document reference: 4417A2024



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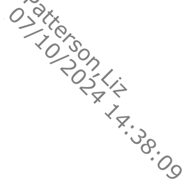
[Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.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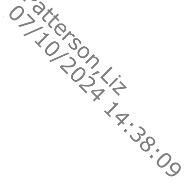


Detailed report

Introduction

1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand; the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.

2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total[1] deficit expected by Welsh Government.

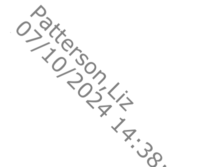
3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

4 Given the challenges outlined above, the objective of our review has been to examine whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. The detailed audit criteria are set out in **Appendix 1.**

5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.

6 We undertook our work between December 2023 and March 2024. The methods we used to deliver our work are summarised in **Appendix 2**. Our work comments on the approach within the Health Board to identifying, delivering, and overseeing cost saving opportunities. It considers the impact these arrangements had on the 2023-24 year-end position and highlights where arrangements may need to be strengthened for 2024-25 and beyond.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[1] Revised deficit positions for 2023-24, known as 'control totals', were allocated to Health Boards by Welsh Government in November 2023 following the provision of additional funding to support their financial positions.

Key findings

7 Overall, we found that **while the Health Board met its agreed deficit target for 2023-24, its recent track record of delivering against its overall savings targets is very variable. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on introducing a new, more financially sustainable service model and to ensure it has the necessary skills and capacity to support the changes required.**

8 The findings that support our overall conclusions are summarised below under the following headings:

- Identifying cost savings opportunities.
- Delivering cost savings plans.
- Monitoring and oversight of savings plans.

Identifying cost savings opportunities

9 We considered whether the Health Board:

- has a clear understanding of the factors that are driving its costs;
- routinely uses a range of data and intelligence to help identify cost savings opportunities; and
- has an effective approach to selecting cost savings opportunities.

10 We found that **the Health Board has a good understanding of its cost drivers, and a clear process for identifying and selecting cost savings opportunities. While the Health Board recognises the need to transform its service model to achieve financial sustainability, it will need to accelerate the pace of this work to prevent its financial position from deteriorating further.**

Understanding the drivers of cost

11 The Health Board has a good understanding of the factors driving its costs, which are clearly set out in its 2024-29 Integrated Plan. These include continuing healthcare, commissioned activity, variable pay, inflationary cost pressures (including energy and prescribing costs), and the ongoing costs associated with responding to the legacy of the COVID-19 pandemic. The Health Board recognises the financial sustainability risks presented by overspending on its main cost drivers, and has endeavoured to better contain expenditure through, for example, enhancing reporting and scrutiny on expenditure at Board and committee levels. However, despite these actions, the Health Board continues to overspend on all its main cost drivers. £

12 Although the Health Board achieved its control total deficit of £12 million in 2023-24, its underlying financial deficit deteriorated and now stands at £25.4 million. In March 2024, the Health Board submitted an Annual Plan for 2024-25 with a savings target of £7.9 million and a projected deficit of £24.9 million. However, the

plan was deemed not acceptable, credible, or supportable by Welsh Government in relation to the financial position. As a result, the Health Board agreed in May 2024 to commit to an additional £2 million of savings to reduce its deficit to £22.95 million for 2024-25 as well as to further explore an additional £2 million with an ambition to reduce the deficit to £20.95m for 2024-25. As of July 2024, verbal feedback provided by Welsh Government indicated that the plan remained unsupportable. At the time of reporting, the Health Board was awaiting a formal response from Welsh Government before considering next steps.

13 The Health Board recognises that it needs to transform its services to better control its cost drivers and achieve long-term financial sustainability. It has therefore committed itself to developing a sustainable model for health and care for the area - the Accelerated Sustainable Model[2]. The 2023-26 Integrated Plan sets out a three phased approach (discover, design, and deliver) to introducing the model and identifies the programmes that will be the focus of the delivery phase, these being: frailty and the community model, speciality, diagnostic and planned care, and mental health. At the time of our review, the Health Board was beginning to develop plans around identifying demand and capacity, prioritisation, phasing, and delivery of this work. While this transformation approach is appropriate and necessary, the potential costs and savings associated with the model are not yet clear. Furthermore, the timescales associated with introducing the new model will require the Health Board to continue identifying and delivering savings, particularly in the short-term. The Health Board, therefore, should clearly set out the costs and savings associated with the model, as well as accelerate this work at pace to place its finances on a more sustainable footing at the earliest opportunity. (**Recommendation 1**)

Using data and intelligence to identify and select cost savings opportunities

14 The Health Board has generally effective arrangements in place for using data and intelligence to identify and select savings opportunities. The Health Board established an Opportunities Group in July 2023 which is led by the Executive Director of People and Culture and includes the Deputy Director of Finance, Executive Director of Operations, Executive Medical Director, Assistant Director of Finance, and Assistant Director of Research and Innovation. The group considers potential savings opportunities based on data and intelligence from several key sources such as teams and departments, directorate reviews, continuing development of the Accelerated Sustainability Model, and benchmarking data from

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[2] The model will be informed by the principles of the Wellbeing of Future Generations (Wales) Act (2015) and values-based healthcare with the aim of transforming the services the Health Board provides and improving outcomes, experience, and cost. Values-based healthcare aims to achieve better outcomes for patients at reduced cost. This could be through, but not limited to elimination of harm, reducing over-treatment and procedures with limited clinical effectiveness, or adopting alternative or preventative approaches.

NHS Benchmarking, CHKS[3], medicines management, VAULT[4], and the NHS Wales efficiency framework. It also considers potential savings ideas generated via the Health Board's 'Bright Ideas' initiative. The initiative has generated 134 responses to date, of which fifty-eight were identified as having the potential to deliver savings. However, there is scope for the Opportunities Group to consider opportunities arising from other sources of data and intelligence, including the findings of Getting it Right First-Time (GIRFT) [5] reviews that directly apply to the Health Board. (**Recommendation 2**)

15 The Opportunities Group allocates potential savings ideas to a series of newly established Working Groups aligned to the themes of the national Value and Sustainability Board (variable pay, non-pay, complex healthcare, medicines management, and service reconfiguration). The role of these working groups is to assess the cost saving opportunity context and determine how to implement it where applicable. However, the Health Board indicated that there are challenges in identifying cost savings opportunities that are relevant to its service model, as most of the comparative information focusses on the provision of secondary care which it commissions rather than provides directly.

16 Viable savings schemes are presented to the Opportunities Group and a Review Panel (which includes representatives from clinical and compliance services) for further scrutiny and quality assurance. Recommendations made by the Opportunities Group to Board are informed by an integrated quality and equality impact assessment to ensure the selected savings schemes have the least adverse impact on strategy, quality, and performance. The Health Board's Impact Assessment Advisory Group reviews and provides specialist input into the development and quality of impact assessments. Until recently, the Health Board had a 'cautious' risk appetite towards financial sustainability due to its concerns about the potential adverse impact of savings on the quality and safety of services. However, it has now adopted an 'open' risk appetite towards financial sustainability, indicating that it is willing to consider all options and choose the ones most likely to result in successful delivery while providing an acceptable level of benefit.

17 The Health Board has also established a values-based healthcare programme as a key approach to achieving long-term financial sustainability. The programme, which is led by the Executive Medical Director and the Deputy Chief Executive/Executive Director of Finance, Capital and Support Services includes key objectives for the Opportunities Group to drive improved value across pathways, including WET Age-Related Macular Degeneration, cataracts, and musculoskeletal conditions.

[3] Caspe Knowledge HealthCare Systems (CHKS) is a provider of healthcare intelligence, benchmarking, and quality improvement services.

[4] The Value, Allocation, Utilisation and Learning Toolkit (VAULT) is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

[5] Getting it Right First Time (GIRFT) is a programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

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Delivery of cost savings opportunities

18 We considered whether the Health Board has:

- a good track record of delivering savings plans and cost improvements;
- clear plans in place to deliver the cost savings opportunities it identifies; and
- the necessary skills and capacity to deliver its agreed cost savings opportunities.

19 We found that **the Health Board's ability to deliver its overall savings targets has varied significantly. However, of the savings delivered in recent years, the majority have been recurrent in nature. This varied track record, coupled with skills and capacity gaps in key areas, presents risks to achieving its 2024-25 savings targets.**

Track record of delivery savings plans and cost improvements

20 As shown in **Exhibit 1**, the Health Board's ability to deliver its overall savings targets has varied significantly. However, its performance has improved recently, with the Health Board delivering 84% of its savings target in 2023-24 compared to 22%, 29%, and 9% in 2022-23, 2021-22, and 2020-21, respectively. However, of the savings achieved each year, most of the savings delivered were recurrent in nature – 86% in 2023-24, 80% in 2022-23, and 100% in 2021-22 and 2020-21, respectively. Indeed, the Health Board delivered significantly higher levels of recurrent savings in 2023-24 compared with previous years.

21 Whilst these improvements are positive, it should be noted that the Health Board did not adjust its original 2023-24 savings target to reflect the £3.2 million of mitigating actions required to achieve its control total deficit of £12 million. Had it done so, it would only have delivered 59% of its savings target in 2023-24 (compared to 84%), with 50% of these recurrent in nature (compared to 86%). However, as we discuss in **paragraph 33**, the Health Board reported to its Board that it had delivered £12.1 million savings by Month 12 2023-24 due to the fact it recognised accountancy gains, which are non-recurrent in nature and reported separately to Welsh Government. The Health Board's varied track record on savings delivery, its reliance on non-recurrent savings to meet the additional savings required in 2023-24, and growing cost pressures continue to present risks to its financial sustainability.

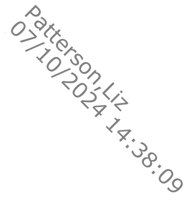

Exhibit 1 – Health Board's savings track-record between 2018 and 2024

Year	Overall Savings Target £(M)	Actual overall savings delivered (£M)	Recurrent savings as a % of overall savings target	Delivered non-recurrent savings (£M)	Delivered recurrent savings (£M)
2018-19	3.5	3	76%	0.3	2.7
2019-20	5.6	3.4	45%	0.9	2.5
2020-21	5.6	0.5	9%	0	0.5
2021-22	1.7	0.5	29%	0	0.5
2022-23	4.6	1	17%	0.2	0.8
2023-24	7.5	6.3	72%	0.9	5.4

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports.

Approach to delivery of savings plans

22 The Health Board has clear arrangements in place for turning its high-level savings requirements into deployable savings plans. Corporately, there are clear lines of accountability for savings delivery with Executive Directors issued an accountability letter which sets out several financial requirements including a savings target. Responsibility for individual savings scheme delivery is delegated to the relevant operational lead and finance business partner[6]. Savings are integrated into business as usual and removed from budgets to reflect operational reality.

23 However, the performance of individual savings schemes during 2023-24 suggests there is scope for the Health Board to set more realistic and achievable targets for some of its schemes going forward. For example, it experienced some significant savings shortfalls against its commissioned services target during quarter three 2023-24. However, this did not materially impact delivery of the initial overall

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[6] The finance business partner model ensures engagement on financial management and provides a good link between services and corporate finance. The financial business partners are financial accountants who have responsibility for supporting services, financial reporting and providing an advisory role.

savings target as it was offset by over-delivery of savings in other areas, namely medicines management (£1 million against a target of £0.490 million), non-pay (£3.1 million against a target of £2.6 million) and pay expenditure (£0.843 million against a target of £0.526 million).

24 The performance of some individual savings schemes during 2023-24 also suggests there is scope to strengthen delivery arrangements. For example, pay savings form a substantial element of the Health Board's savings plan, and within that a requirement to reduce agency costs. In August 2023, the Delivery and Performance Committee received an update on agency pay which highlighted that the Health Board was experiencing another year of increased agency costs. As a result, the Health Board established an agency spend reduction programme and developed a project plan with several areas of focus. Despite this, there was an overspend of £2.3 million against the year-to-date plan at Month 12 2023-24, which suggests that the action plan and associated delivery arrangements were not sufficiently robust in delivering the intended aims of the programme. (**Recommendation 3**)

25 The Health Board has effective mechanisms for communicating its cost savings plans to staff, service users, and other stakeholders. It actively communicates with staff using its financial sustainability page on its intranet site, wellbeing roadshows, discussion of finance reports at the Local Partnership Forum and 'Chat 2 Change' Network comprising of trade union members and staff champions. We also note the Health Board's approach to staff engagement in delivering savings through staff reductions within its cleaning, catering, and portering services. We found evidence of good communication and support to staff in helping them understand the reasons and implications of the changes. Public Board meetings continue to be held virtually and livestreamed, with supporting papers including finance reports made available on the Health Board's website.

Skills and capacity to deliver savings opportunities

26 The Health Board has an overall skills and capacity gap in respect of the financial and transformational aspects of savings delivery. Aside from its Opportunities Group, which includes a wide range of expertise from across the organisation, the Health Board has limited innovation and improvement resources at its disposal. Consideration was given to establishing a Programme Management Office (PMO). However, given its potential scale, the PMO would also need to rely on additional support from the corporate finance team which is already stretched given the Health Board's financial challenges and increased external scrutiny. The Health Board has recently completed an assessment of the capacity, capability, and sustainability of the Finance Team. It found that the Finance Team lacks adequate senior level capacity, and it is therefore intending on recruiting an additional finance business partner to strengthen its operational and corporate capacity to deliver savings. In addition, finance reports consistently highlight capacity risks across wider operational teams which also impact on their ability to focus on savings delivery. (**Recommendation 4**)

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27 The Health Board highlights transformational capacity as a critical risk in its Corporate Risk Register and identifies several controls and mitigating actions to actively manage the risk. However, at present, it does not have a complete understanding of the skills and capacity it requires to deliver its Accelerated Sustainable Model, which is crucial to it delivering the efficiencies and savings required to achieve long-term financial sustainability. This is an area that will need to be addressed if the Health Board is going to be successful in moving away from its approach of delivering short term non-recurrent savings to one where more complex transformational areas of change help deliver its future financial targets. (**Recommendation 5**)

Monitoring and oversight of cost savings delivery

28 We considered whether the Health Board:

- has an effective approach to reporting and monitoring the delivery of its cost savings plans;
- identifies risks to the delivery of savings plans and actions to mitigate those risks; and
- applies learning where cost savings plans have not been achieved.

29 We found that **the Health Board has reasonably effective arrangements for monitoring and reporting on cost savings. However, opportunities exist to provide stronger assurances that key cost reduction plans are achieving their intended impact, to strengthen risk management arrangements, and to introduce a systematic approach for learning lessons from savings planning and delivery.**

Reporting and monitoring the delivery of savings plans

30 The Health Board has reasonably effective arrangements for monitoring and reporting delivery of savings. At a corporate level, overall delivery against savings targets is reported to the Executive Committee, the Delivery and Performance Committee, and the Board as part of the routine finance reports. The reports are clear and provide an overview of progress against individual and collective savings targets and identify risks and mitigating actions. They also include links to the Health Board's monthly monitoring returns to Welsh Government which includes further detailed savings information.

Identification of risks to savings plans delivery

31 As highlighted in our Structured Assessment work, the Health Board has operated without an updated Board Assurance Framework (BAF) for several years until the Board approved an updated BAF in May 2024. Despite this, there has been visibility of broader financial risks at Board and committee-level with good scrutiny and oversight of the information presented. During 2023-24, the Health Board's Corporate Risk Register included a risk relating to the management of financial

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resources during the year and over the medium- term. Both elements of the risk have been RAG[7] rated red with broadly similar risk scores, controls, mitigating actions and their impact.

32 The Health Board has generally satisfactory arrangements for identifying savings delivery risks at an operational level, and we saw good evidence that it has captured this information for some of its schemes such as medicines management and its catering, domestic and porter services savings plans. However, this was not the case across all schemes. As a result, the Health Board should strengthen its approach to identifying and documenting mitigating actions across all schemes to demonstrate it is actively managing and mitigating operational savings risks. (**Recommendation 6**)

33 Like all NHS bodies in Wales, the Health Board assesses (RAG rates) its savings schemes to determine the extent of risk of non-delivery. At Month 3 2023-24, the Health Board identified that 63% of its savings schemes were 'amber'. Welsh Government requires amber schemes to turn to green schemes (i.e. a strong likelihood of delivery) within three months. The Health Board's finance report to the Delivery and Performance Committee identified an action to develop increased certainty on 'amber' schemes so that they turn 'green.' Positively, four months later, at Month 8 2023-24, the Health Board reported that only 1% of its savings schemes remained 'amber' demonstrating that it was addressing savings risks quickly. The Health Board also identifies red savings schemes in its finance reports to the Delivery and Performance Committee which shows pipeline opportunities that need to be converted into deliverable plans. At Month 12 2023-24, the Health Board reported that £12.1 million of 'green' rated schemes had been achieved, which included accountancy gains of £5.7 million. However, it still had £4.2 million of 'red' pipeline opportunities which were not converted into deliverable 'green' or 'amber' schemes. (**Recommendation 7**)

Applying learning

34 The Health Board has generally effective arrangements for evaluating, improving, and embedding its cost savings arrangements. It routinely considers and seeks assurance from Internal Audit work through its Audit, Risk, and Assurance Committee (ARAC). At its meeting in June 2023, the ARAC considered an Internal Audit report on the Health Board's Savings Plans and Efficiency Framework, which gave reasonable assurance, and made several medium and low risk recommendations to improve the arrangements. The implementation of the recommendations was monitored using the Health Board's Internal Audit Recommendations tracker, and an update to the ARAC in January 2024 indicated that all recommendations have been completed.

35 During 2023-24, the Health Board demonstrated that it was able to respond at pace to changing financial circumstances. It rapidly established its Opportunities Group to identify additional savings in response to Welsh Government's request in

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[7] Red, Amber, Green.

July 2023, and where performance against its original savings target of £7.5 million was off track. Consequently, it met its revised control total deficit of £12 million. Whilst it did so through delivery of mainly non-recurrent savings, it would not have achieved this had it not identified additional savings opportunities or expanded key workstreams to consider savings from other aspects of the Health Board's business. The Health Board, therefore, should seek to identify the key lessons from this experience and apply the learning to its future approach to financial savings, with the aim of moving away from its reliance on non-recurrent savings. (**Recommendation 8**)

Recommendations

36 **Exhibit 2** details the recommendations arising from this audit. The Health Board's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 2: Recommendations

Recommendations
R1 The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potential costs and savings that will arise through its introduction in order to place its finances on a more sustainable footing. **(Paragraph 13)**
R2 The Health Board should make greater use of Getting it Right First-Time (GIRFT) reviews that directly apply to the Health Board as a further source of potential intelligence to inform its savings identification arrangements. **(Paragraph 14)**
R3 The Health Board should set challenging but realistic targets for its individual savings schemes. It should also develop robust but achievable action plans for its schemes accompanied by suitable delivery arrangements to ensure they achieve their intended aims. **(Paragraphs 23 and 24)**
R4 The Health Board should broaden its assessment of capacity beyond its Finance Team to identify and develop plans to address any shortfall or gaps in available resource in its wider operational teams. **(Paragraph 26)**

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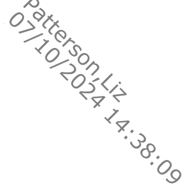
Recommendations	
R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the Accelerated Sustainable Model. **(Paragraph 27)**
R6	The Health Board should clearly identify savings delivery risks, and mitigating actions within in its corporate and operational risk management arrangements. **(Paragraph 31 and 32)**
R7	The Health Board needs to prioritise how best to turn its red savings schemes into recurrent green and amber schemes that have a realistic chance of delivering the identified savings. **(Paragraph 33)**
R8	The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach with the aim of placing less reliance on non-recurrent savings. **(Paragraph 35)**



Appendix 1

Audit criteria

Exhibit 3 below sets out the detailed audit criteria for this review**.**

Identifying cost savings opportunities

Area	Audit Criteria
Understanding the drivers of cost	• The organisation's opening balance sheet is true and fair. • The organisation has effective arrangements in place for identifying and analysing the full range of pay and non-pay factors driving its costs in the short, medium, and long-term. • The organisation has a good understanding of the scale of cost savings required to achieve financial sustainability in the short, medium, and long-term and has set realistic and achievable targets accordingly. • The Board is appropriately involved in overseeing, scrutinising, and challenging the organisation's financial analysis and cost savings targets.
Using data and intelligence to identify cost savings opportunities	• The organisation routinely accesses and uses benchmarking information from a range of sources (e.g. NHS Benchmarking, CHKS, Medicines Management KPIs) • The organisation routinely accesses and uses efficiencies data and information from a range of sources (e.g. NHS Wales Efficiency Framework / VAULT, GIRFT reviews, local Value-based Healthcare reviews / opportunities)

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Area	Audit Criteria
	• The organisation has clear processes in place to canvas, capture, and assess ideas and suggestions on cost savings opportunities from staff, service-users, and other stakeholders on a regular basis. • The organisation has clear processes in place for responding to centrally identified cost savings opportunities from the NHS Wales Value and Sustainability Board.
Selecting cost savings opportunities	• The organisation has a clear and iterative process in place to appraise all potential cost savings opportunities for achievability and for impact on delivering the organisation's strategic aims, well-being objectives, population health, the quality and safety of services, and ability to meet performance targets / service specifications in the short, medium, and long-term. • The organisation has a clear and iterative process in place for scrutinising, agreeing, and approving cost savings opportunities, which also involves the Board and its relevant committee(s). • The organisation's agreed cost savings opportunities: – are realistic, achievable, and focus on maximising value to the health of the population being served; – cover the breadth of the organisation's clinical, administrative, and technical functions; – balance one-off non recurrent savings with more sustainable saving opportunities; – incorporate productivity savings, but recognise these will not lead to a reduction in monetary terms; and – focus on medium- to longer-term transformation, as well as short-term and incremental opportunities. • have been scaled and targeted appropriately across all parts of the organisation (rather than a standard percentage applied across all parts.)

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Delivery of cost savings opportunities

Area	Audit Criteria
Approach to delivery of savings plans	• The organisation has plans in place for delivering cost savings opportunities which clearly set out: – the financial savings that will be delivered and how they will be measured; – the anticipated impact on strategy, quality, and / or performance; – the key risks, controls, and mitigating actions; – any interdependency with other cost savings plans; – any dependency on other organisational work streams and strategies; – key delivery milestones; and – which senior officer is responsible and accountable for delivery. • The organisation has effective arrangements in place for managing cross-cutting cost savings plans. • The organisation has appropriate arrangements in place to communicate its cost savings plans to staff, service-users, and other stakeholders.
Skills and capacity to deliver savings opportunities	• Roles and responsibilities in relation to delivering cost savings plans at all levels of the organisation are clearly documented and understood. • The organisation has assessed the skills / capability and capacity required to deliver its cost savings plans at both a corporate and operational level and has put appropriate arrangements in place to address any shortfalls and gaps (including the appropriate use of external capacity / expertise.) • The organisation has appropriate corporate structures and resources in place (such as a Programme Management Office) to: – keep delivery on track, – provide challenge when needed, – support corporate and operational staff to manage delivery risks, and – provide an agile and timely response to under-performance / under-delivery.

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Area	Audit Criteria
Track record of delivery savings plans and cost improvements	• Cost savings plans in recent years have been largely achieved. • There is evidence of learning being applied where cost savings plans previously haven't been achieved.

Monitoring and oversight of cost savings delivery

Area	Audit Criteria
Monitoring the delivery of savings plans	• The organisation has clear arrangements in place for monitoring delivery which reflect the timescales and risks associated with delivering individual plans and the overall cost savings target. • The organisation has selected appropriate key KPIs and has put effective controls in place to ensure the quality of underlying data are reliable for effective monitoring and reporting. • The organisation's approach to monitoring and tracking delivery of its cost savings plan is appropriately aligned to its broader financial management arrangements (e.g., Standing Financial Instructions, Schemes of Reservation and Delegation, budget allocations.) • The organisation produces tailored reports that meet the differing needs of users in the governance chain. • The organisation ensures that delivery of cost savings is accurately reflected in finance reports presented to the Board and / or its relevant committee(s).

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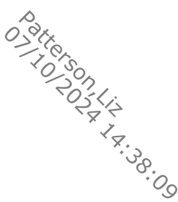
Area	Audit Criteria
Identification of risks to savings plans delivery	• The organisation has identified and documented the key risks to delivery in the appropriate risk registers (operational, corporate, and Board Assurance Framework.) • The organisation is actively managing / mitigating the risks at the appropriate level. • The organisation has appropriate arrangements in place to identify and escalate cost savings plans that are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance. • The organisation takes appropriate action in a timely manner where cost savings plans are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.
Applying learning	• The organisation seeks assurance on its arrangements by using internal audit, or a similar independent and objective reviewer. • The organisation appropriately evaluates its approach to achieving cost savings. • The organisation actively uses its own evaluation(s) and assurances provided by internal audit to identify lessons learned and to change / improve its arrangements. • Lessons learned and changes / improvements are reported to the Board and / or its relevant committee(s) to enable an agile response in-year. • The organisation has appropriate arrangements in place to fully transfer and / or integrate changes arising from its cost savings plans to its business-as-usual operations and activities.

Appendix 2

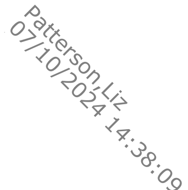
Audit methods

Exhibit 4 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Self-assessment	The Health Board completed a self-assessment structured around the audit criteria ("What We Looked At").
Documents	We reviewed a range of documents, provided in support of the self-assessment, including: • Board and Committees agendas, papers, and minutes • Key organisational strategies and plans • Savings benchmarking data • Key risk management documents, including the Corporate Risk Register



Element of audit approach	Description
	• Key reports and plans relation to organisational finances and savings • Reports prepared by the Internal Audit service
Interviews	We interviewed the following senior officers and Independent Members: • Dr Carl Cooper – Chair of the Board • Hayley Thomas – Chief Executive Officer • Pete Hopgood – Deputy Chief Executive/Executive Director of Finance, Capital and Support Services • Stephen Powell – Executive Director of Planning, Performance and Commissioning • Debra Wood Lawson – Executive Director of People and Culture • Dr Rhobert Lewis – Independent Member • Hywel Pullen – Deputy Director of Finance
Observations	We observed Board meetings as well as meetings of the following committees. • Public Board • Board Development Session • Delivery and Performance Committee



Appendix 3

Management response to audit recommendations

Exhibit 5: Health Board's management response to our audit recommendations

Ref	Recommendation	**Management response** Please set out here relevant commentary on the planned actions in response to the recommendations	**Completion date** Please set out by when the planned actions will be complete	Responsible officer (title)
R1				
R2				

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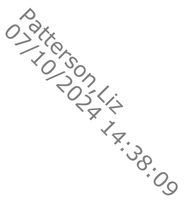
We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



AUDIT, RISK AND ASSURANCE COMMITTEE, 08 October 2024	Agenda Item 3.5
Subject:	Audit Recommendations Tracking (Internal and External Audit)
Approved and Presented by:	Director of Corporate Governance
Prepared by:	Senior Administrator
Purpose:	The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 31 August 2024.
Recommendations:	The Audit & Risk Assurance Committee is asked to: • **CONSIDER** the current position of outstanding Audit Recommendations and take **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.

Executive Summary:	The responsibility for the collation, monitoring and reporting of internal and external (Audit Wales) audit recommendations is the responsibility of the Corporate Governance Team. Information is managed throughout the year and reported to the Executive and Audit & Risk Assurance Committees on a regular basis.
	
	The last report was received by the Audit & Risk Assurance Committee on the 14 May 2024.
	
	The report provides the following information:
	
	• Internal Audit Recommendations that:
	    • remain OUTSTANDING
	    • are COMPLETED since the previous report
	    • Are NOT YET DUE for implementation
	
	• External Audit Recommendations that:
	    • remain OUTSTANDING
	    • Are NOT YET DUE for implementation
	
	The report also confirms there are no outstanding recommendations from Local Counter Fraud Services Pro-Active Exercises.

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SUMMARY POSITION – Internal Audit

Internal Audit – Completed since last report

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High			1	1	2	1	5
Medium			1		2	2	5
Low						1	1
Total	0	0	2	1	4	4	11

Internal Audit – Not yet due for implementation

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High		1			6	2	9
Medium					3	16	19
Low					5	2	7
Total	0	1	0	0	14	20	35

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Summary since the last report in : JULY 2024

- 11 actions have been completed since the last report
- 35 actions are not yet due for implementation of which 9 are high (26%)

Internal Audit – Remain Outstanding

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High	1		1		1	1	4
Medium	3	1	1	3	2	3	13
Low					1	1	2
Total	4	1	2	3	4	5	19
Status	All overdue	All overdue	All overdue	2 overdue	All overdue	N/A	

Summary

- 19 actions remain outstanding or are overdue of which:
  - 4 (21%) are high priority (increased from 13%)
    - Care Home Governance – overdue, partially completed
  - 13 (68%) are overdue
    - 12 are partially completed
    - 1 has no progress (Ref - 212207 2021/22 Dementia Services) – due to lack of funding
  - 3 are from the last financial year
  - 3 (15%) relate to Limited to No Assurance Reports
  - 16 (84%) relate to substantial or reasonable assurance reports

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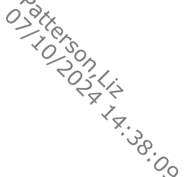
Actions being Taken:

- Lead Executives continue to give priority to the overdue recommendations and provide further updates – this will take into account recent changes in executive portfolios
- Further updates will be provided to the Committee in the next report in March 2025.



External Audit – Completed since last report

Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	All complete	All complete	All complete	0	0	0

External Audit – Not yet due for implementation

Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	All complete	All complete	All complete	1	12	13

External Audit – Remain Outstanding/Overdue

Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
	All complete	All complete	All complete	1	0	1
Total						1

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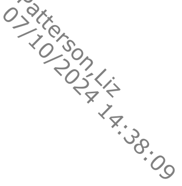
Summary since the last report in May 2024:

- 1 action remains outstanding or is overdue
  - Structured assessment – framework for Board walkarounds – date revised to Sept 2024
- 1 action is not yet due for implementation from the last financial year (2023/24)
- 13 actions are not yet due for implementation – all from the current financial year (2024/25)



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Appendices:

The following appendices are provided with more details:

- 7.2a – Internal audit - recommendations completed since last report
- 7.2b – Internal audit - recommendations not yet due
- 7.2c – Internal audit - recommendations outstanding
- 7.2d – External audit – recommendations not yet due
- 7.2e – External audit – recommendations that remain Outstanding

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No. Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending	When will implementation be achieved?	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
212203	Medical Equipment and Devices	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Head of Clinical Education / Medical Device & POCT Manager	R5	1. The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 2. The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	1. Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group is scheduled for 8th November, this was delayed at the request of Clinical Education as waiting for new members of the team to commence into post. The aim of the group will be to pilot a process for a small number of devices. Once this is in the place, the same process will be rolled out for all devices and all staff groups. 2. Management will ensure manufacturer's instructions are stored digitally via the Medical Devices Intranet page where applicable. Capacity to undertake this task is limited. Responsibility for this role and timeframe for completion to be identified.	Mar-22		Complete		Complete		Training matrix has been developed and shared with Governance Leads for review. Shared with MD&POCT Group members in October 2022 and agreed at November MD&POCT Group. Comments received and to be added to matrix. SBAR is being drafted to identify the issues and risks around training. **November 2023**: T&F Group implemented to progress this work. Additional sub group set up to focus on Syringe Drivers. Positive engagement from key stakeholders. **January 2024:** Syringe Driver Training held November 2023. T&F group continues to progress towards making recommendations to implement improvements to training provision. **March 2024:** T&F Group to continue to make recommendations to implement improvements to training provision and recording compliance. Team will scope options for collecting the infomation with a specific audit. **June 2024:** 1. Short questionnaire developed for completion by service leads to gather information on current recording methods for medical device training. Results to be available by end of June 2024. INR refreseher training is now available live on ESR and Learning@Wales for secondary & primary care staff using Roch Coaguchek devices. 2. Manufacturers Instructions now stored digitally via SharePoint. Not complete for all devices but a process is now embedded. Request revision of deadline to September 2024. **July 2024:** Recommendation/action 2 complete. Target deadline for recommendation 1 September 2024.	Resource within Medical Devices Team.	Implementation of new devices on a health board basis incorporate training and recording via ESR.	Assurance on devices already in use will take some time to obtain through ensuring all staff are appropriately trained and competent, recieve updates at agreed intervals and that robust recording processes are in place. Gradual progress being made but unable to define a specific completion date due to capacity constraints Target Date for completion is June 24		28	1495	Aug-24			
212203	Medical Equipment and Devices	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Governance Leads / Medical Device & POCT Manager	R7	1. Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy. 2. Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 3. A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.	1. Actions and improvements will be made through the POCT Group. Processes will be implemented for monitoring compliance and will be developed through the POCT Group in collaboration with service group Governance Leads. 2. The Management of POCT policy will be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form is already included in the Management of Medical Devices and Equipment Policy. Will be raised through POCT Group in relation compliance with policy. 3. All new POCT devices will have SOP's in place prior to implementation. The management, in conjunction with Governance Leads, will ensure all current Point of Care Testing Devices have SOP's in place and that they are regularly reviewed and updated accordingly. This work will be implemented through the POCT group.	Dec-22		Complete		Complete		WPOCT implementation will strengthen governance in terms of quality control checks. WPOCT project has commenced but not completed. Project Manager role has progressed but delay in IG approval has impacted on being able to deliver within a specified timescale. **November 2023 Update:** Success bid for 6 goals funding has progressed to appointing a POCT Co-ordinator on a temporary basis. Anticipated start date of mid-January'2024. This post will enable key elements within these recommendations to be progressed. An SLA arrangement with ABuHB will support this post in terms of governance and technical support. **January 2024:** The POCT Coordinator is now in post and has begun work on reviewing existing policies and SOPs. A plan of works has been put in place for all existing devices. The priority for the first quarter 2024/25 is to implement the all-Wales POCT specific Data Management system (WPOCT). This will allow for extensive monitoring of all IQC & EQA and give the department control of user access to devices based on user training & competency on all connected devices. POCT Coordinator will ensure that all SOPs and governance documents will be updated and/or drawn up prior to devices going live on WPOCT. User training will emphasise personal responsibility for staff to carry out IQC/EQA and reminders sent out via clinical refresher training and via PTHB Intranet adverts. **March 2024:** POCT Co-ordinator now in post for 2 months and continues to work through priorities as listed in January 2024 update. **June 2024** 1. EQA Schemes INR devices- SBAR written for Secondary Care scheme, while Primary Care have been informed via Jennie Morgan of the requirement to sign up individually to an EQA scheme. iStat devices within respiratory are already enrolled in EQA scheme Glucose meters will be enrolled in EQA scheme at the start of new contract. IQC WPOCT implementation is going through final stages of IG scrutiny and will provide oversight and control of IQC on connected devices. Suggest IQC/EQA compliance be added to department audit schedule and KPIs for long term tracking. 3.SOPs for POCT Devices Respiratory Team writing SOPs for their iStat devices, POCT Coordinator meeting with them regularly to offer support. Nova Glucose meter SOP currently under review by POCT Coordinator with main changes & training materials now agreed with Sally Ann Jones. INR SOP under review and POCT coordinator collating list of proposed changes to take to Clinical Lead. Lucie Cornish working with POCT Coordinator to identify list of appropriate Clinical Leads for approving POCT SOPs in the future. **Following approval of SOPs this action can be closed. Anticipated Q2 2024/25 - request to revise deadline.** **July 2024: 1. EQA scheme for PTHB owned devices funded and will be in place from September 2024. This recommendation is complete.** **3. SOPs - agreed changes to be written up following review by clinical leads. Still aiming for Q2 2024/25 for closure.**	Resource prevents progress in this area.	Awareness raised through Governance Leads of the importance of quality control checks and robust recording, abeit currently in manual format.	Funding has ceased for the Project Manager role, and following IG delays this has significantly impacted implementation. Gradual progress is being made in WPOCT implementation for INR devices across all sites; revision of timescales in light of project manager funding ceasing is underway. This role will need to be absorbed within the MD&POCT Team. This is proving a challenge from a capacity, skills and knowledge aspect. Further discussions held with neighbouring health board and agreement from Executive Director to explore options to strengthen POCT governance within the health board. Briefing paper under development. Success bid for 6 goals funding has progressed to appointing a		15	1491	Aug-24			
222317	Cyber Security	Limited	Director of Allied Health Professions, Health Sciences and Digital	Head of Infrastructure & Cyber Security and ICT Service Delivery Manager	R2	The asset management software should be brought 100% up to date by reconciling it with a physical stock check of all digital equipment as necessary. All 'spare' equipment should be returned to a central location where it can be securely stored and maintained.	At the time of the Audit a plan was already in place to address asset information. As mentioned above, increasing awareness of asset information will allow us to demonstrate the coverage of our technical solutions, highlighting gaps and improving compliance, particularly so with physical storage of assets held within Service areas. There is a plan to perform a physical audit in addition to the electronic inventory.	Oct-24		Complete		Complete		Significant work as been completed to cleanse data withing active directory to provide a clearer picture of assets currently in use in the health board, this will be continually reviewed and updated until the data accuracy provides little or no room for error. SysAid will become the authoritative asset managment solution based on existing records and information of live assets from active directory. **02/04/24** The Asset Refresh 2024/25 programme is scheduled and will continue to support an up to date record of assets and means legacy equipment will be refreshed and accurately recorded as part of the full Asset Management lifecycle and associated process. Full physical site audits will continue with a priority given to Brecon and Bronllys. Sysaid has been replaced by a new ITSM solution called HALO. This was agreed to transition to BAU and IA action closed at the May D&P Committee				yes	11	1491	Aug-24	Mar-23	yes	
232416	Information Governance	Limited	Director of Corporate Governance/ Board Secretary	Head of Information Governance, Records and DPO	R1	The Health Board should ensure that a full assessment of needs and resources is undertaken to identify gaps and risk areas upon which capacity and resilience can be appropriately measured, including but not limited to the following: • all current and upcoming legislative duties, tasks, and strategic developments segregated into corresponding areas such as Records Management or IG; • approximate average time to resolve requests based on level of complexity (until a more suitable solution can be achieved with the Digital Transformation Team); • resource utilisation metrics e.g., total 'billable' hours / total available working hours x 100	Accept: Work is being undertaken to identify and deploy a suitable digital solution that the IG team can use which will capture all information required to support a full needs analysis.	May-24		Complete		Complete		**5/2/24** - Digital Solution currently under development with plans to deploy within the team 1/4/24. This IG Tracker will capture all IG Activites, including time taken to complete them. **14/6/24** - A digital solutio has been identified and the team will start using it during Q2. This deployment of this solution will complete this action. It will however take several months to be able to provide KPI's to enable the service to complete a full assessment of needs and resources. **12/8/24** - A digital solution has been deployed and the IG Team started inputting data from the beginning of August. This recommendation can be closed				yes	#NUM!	1491	Aug-24	Jan-24	Yes	Recommendation met and the solution deployed will start to capture all activity coming into the IG Team which in turn will provide the information required to undertake the gap analysis and assess resources within the team.
232416	Information Governance	Limited	Director of Corporate Governance/ Board Secretary	Head of Information Governance, Records and DPO	R3	The Health Board should ensure that IAO and IAA responsibilities are assigned to appropriate individuals with required seniority and capacity to oversee the controls on the information assets and how they are used, within all areas of the organisation.	Accept: Work is underway to engage with Service Leads to identify key staff within their services to take on the role of IAO and IAA and these roles will be supported by the Information Governance Team. Once roles have been assigned, training will be provided to support these staff to understand their roles as IAO or IAA. Ongoing review and reporting on the IAR will be undertaken by the Information Governance Team, IAO and IAA, where risks/issues will be discussed and where necessary reported via the Risk and Assurance Committee for consideration.	Feb-24		Complete		Complete		**5/2/24** - engagement has commenced with Heads of Service to nominate IAO and IAA and responses are being received back in. Training package including roll out is currently being development by the IG Team Work underway with PTHB's BI Team and a scheduled rebuild of the existing Information Asset Register will commence March/April 2024 **14/6/24** - IAOs and IAAs have been identified. Training package has been developed. Testing is underway by the IG Team of the new Information Asset Register platform prior to deployment. It is anticipated this action will be complete by the end of Q2. Uploading of information into the IAR will be reliant on services inputting the data. Once deployed Periodic meetings will be set up to monitor and support progress with the IAR. **12/8/24** - The New IAR Platform has minor amendments being undertaken by digital and is due for launch by the end of August. Therefore this recommendation can be closed				yes	2	1491	Aug-24	Jan-24	No	Recommendation met. New IAR platform has been developed and will be deployed end of August. IAAs and IAOs have been identified across the board, trained and periodic meetings will be set up to provide support
232416	Information Governance	Limited	Director of Corporate Governance/ Board Secretary	Head of Information Governance, Records and DPO	R4	The Health Board should ensure that appropriate IG Leads / Champions are identified within the Health Board to support the IG team by promoting good information governance practice.	Accept: Work is underway to engage with Service Leads to identify key staff within their services to take on this role. Once identified work will take place led by the IG Team to utilise these roles to support the IG/Records Workplans to promote good information governance practices in both health and corporate areas. A PTHB Information Governance Advisory Group will be set up to meet biannually, to discuss progress the Information Asset Register agenda and promotion of good Information Governance practices across the organisation.	Mar-24		Complete		Complete		**5/2/24** - engagement has commence with Heads of Service and responses are being received back in. once received, meetings will be set up **14/6/24** - this is linked with R3 as those nominated as IAOs and IAAs will also be identified as IG leads/champions. **12/8/24** - linked to R3 above - this can be closed				yes	1	1491	Aug-24	Jan-24	No	Recommendation met. New IAR platform has been developed and will be deployed end of August. IAAs and IAOs have been identified across the board, trained and periodic meetings will be set up to provide support
232416	Information Governance	Limited	Director of Corporate Governance/ Board Secretary	Head of Information Governance, Records and DPO	R5	The Health Board should ensure that the IAR is progressed by the Information Asset Owners and Information Asset Administrators identified under recommendation 232416_R3	Accept: The existing Information Asset Register is due to move to a new platform in Power BI which will enhance monitoring for completeness and data quality providing better tools for the IG Team, IAO and IAA to ensure all assets are entered in a timely manner and are correct.	Mar-24		Complete		Complete		see R3 above. **12/8/24** - linked to R3 above - this can be closed				yes	1	1491	Aug-24	Jan-24	No	Recommendation met. New IAR platform has been developed and will be deployed end of August. IAAs and IAOs have been identified across the board, trained and periodic meetings will be set up to provide support
242503	Agency Spend Reduction Group	Reasonable	Assistant Director CSG	Director of Primary Care, Community and Mental Health/Director of Finance, Capital and Support Services	R2	The plan should be strengthened. The ultimate goals should be quantified and made SMART. There should be KPI that facilitate tracking and reporting progress against those SMART objectives at regular intervals.	Review and update Action Plan, to include the development of SMART objectives, and the identification and development of KPIs to facilitate effective tracking of the SMART objectives.	Jun-24		Complete		Complete		**Aug 24** - Executive Lead unavailable, so Director of Finance has stepped in and has reframed the arrangements. All actions on original completed and action plan closed. Programme meeting focussed on recent performance, provides challenge and support to key issues (for example identified variance in roster planning across sites, or limitations of Bank staff take up).	None		Aug-24	Yes			Oct-24	Jun-24	Yes	
242503	Agency Spend Reduction Group	Reasonable	Assistant Director CSG	Director of Primary Care, Community and Mental Health	R3	For maximum benefit to be obtained from the dataset being developed the results should be displayed in a dashboard format which is accessible and understandable by ward staff.	Develop and implement a dashboard for current dataset reporting, which can be cascaded to teams including SMT and OMT.	Jun-24		Complete		Complete		All datasets shared monthly - not in dashboard form, but well recognised by oversight group. **Aug 24 - new approach taken**	None		Aug-24				Aug-24	Jun-24	Yes	
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care	R1	Management should ensure that the current version of the SOP is reviewed and updated as soon as possible to ensure that it complies with current governance arrangements within the Health Board and the National Framework.	The SOP was reviewed in 2021 and we are not clear why this version was not available for this Audit. However, we acknowledge the need for a document revision in line with the refreshed Framework and to reflect Executive changes.	31.08.24		Complete		Complete		The SOP has been updated.							Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Director of Corporate Governance	R5	All Directorate/departmental risk management leads should be reminded that key risks that are scored 12 and above should be submitted to the RAG for discussion, with a further view for potential escalation onto the Corporate risk register.	Recommendation accepted and implemented. Requests for directorate risks have been issued and incorporated onto the Risk and Assurance Group agenda for the scheduled meeting on the 18 July 2024 and will be a standing item thereafter.	30/06/2024		Complete		Complete		**August 2024** - recommendation implemented from the July Risk and Assurance Group							Aug-24	Jul-24		

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202108	Partnership Governance – Programmes Interface	Limited	Director of Corporate Governance/ Board Secretary		R1	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes. A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21	Dec-24	Not yet due		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position. **Feb 2022** update - some high level work commenced with this action in 2022 but due to a variety of factors the work has not been completed. The new Director of Corporate Governance / Board Secretary took up post in January 2023 and will ensure the development of the partnership governacne guidance document is included for the 2023/24 year. Revised date requested to 31 March 2024. **April 2023** - action is on track for March 2024, reports will be provided as the year progresses. **April 2023** - The Live Well: Mental health partnership reports to each Regional Partnership Board meeting. An assurance report will also now be included to the Boards Patient Experience, Quality and safety meeting on an annual basis. The report has been added to the Committee's work plan for 2023-24. **Nov 2023** - RPB report introduced at Board level on a bi-annual basis (first report 29 Nov 2023) with enhanced reorting of RPB Board activity at each meeting. The framework is intended to be compkleted for the target date, there is a risk of not achieving this due to staffing capacity, the Board Assurance Framework wil take priority. **Feb 2024** - in Nov 2023, when the Board considered the revised annual delviery plan, the Board agreed that the action be defered to 2024/25. Recommended date change to Dec 2024. all other mitigations mentioned above continue to be in place. **April 2024** - update as per above. Date needs to be changed to Dec 2024. **June 2024** - action remains planned to be completed for Dec 2024. **Aug 2024 -** action remains planned to be completed for Dec 2024	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	Mar-24		34	#NUM!	Aug-24			
232402	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R2	The structure and information held regarding the in-reach arrangements that the Health Board has in place should be reviewed to ensure that it is clear, accurate and unambiguous and can easily show the current position at any time.	Review the schedule of agreements and updated activity levels. Develop and implement new SLA service specification. Increased clarity on reporting requirements. Monthly SLA update/review meetings to be held in addition to CQPR meetings.	Dec-23		Not yet due		Partially complete		PTHB Planned Care Manager and Information are looking at refreshing the Power BI report to ensure all theatre sessions and OP clinics are mapping to the report. Head of Commissioning in process of revising and updating the SLA templates and working with Planned Care colleagues to ensure that the activity level requirements of the SLAs are updated. Continuing to work towards development of service specifications to underpin the SLAs. **09.09.2024** - Service specification template completed, work will now take place during 2024/25 and subsequent financial years to develop service specifications to underpin the SLAs.					8	1495	Aug-24			
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R2	Management should review the main Health & Safety Policy to ensure that the correct references are quoted for all supporting policies noted.	Management will review and update the Health and Safety Policy so that it reflects the correct references for supporting policies.	Mar-24		Not yet due		Partially complete		This policy is being reviewed and will be updated and ratified at the next HSG meeting and re published by April March 2024 this was correct in Feb but is not out of date due to porfolio changes and will be completed by June 2024 and ratified by HSG.	None		Jun-24		1	1491	Aug-24	Jan-24		
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R9	Management should ensure that: • The accountability arrangements for the Fire Safety Group are clarified and the ToR updated accordingly; • The Chair of the Security Oversight Group is reminded of the requirement to provide quarterly highlight reports to the H&S group; and • The ToR for the Site Coordination Forum are reviewed, noting the frequency of meetings requirement.	Management will clarify and correct the TOR for the Fire Safety Group in respect to its accountability arrangements. Chair of the Security Oversight Group to provide a written report for the H&S group on a quarterly basis	Mar-24		Not yet due		Partially complete		The review of all the TOR is ongoing along side the policy framewpork and will be finaliseed at the March HSG March 2024 all the TOR are being reviewed and will be aligned with the revised Health and Safety Policy and ratified in June 2024	None	0	Jun-24		1	1491	Aug-24	Jan-24		
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Head of Quality and Safety	R1	The Incident Management framework should be reviewed and updated so that it includes the incident management governance arrangements, specifically demonstrating the clear lines of reporting across all parts of the organisation, including through to the relevant Committees of the Board.	Update the Incident Management Framework to reflect the Health Board governance arrangements for the management of Nationally Reportable Incidents	Feb-24		Not yet due		No progress							6	1495	Aug-24	Jan-24		
232417	Primary Care Dental Services - Management and Monitoring of General Dental Services Contract	Substantial	Director of Finance, Capital and Support Services	Assistant Director of Primary Care Services	R2	The GDS Monitoring Group Terms of Reference (ToR), and Primary Care GDS Commissioning Assurance Framework should be updated to reflect the revised Health Board Committee structure and reporting arrangements and incorporate version control to ensure its accuracy of content. These documents should also be updated to state the performance metrics that are submitted to the Delivery and Performance Committee via the Integrated Performance Report.	The GDS Monitoring Group Terms of Reference will be updated to reflect the current Health Board Committee Structure and will include the performance metrics that are reported to the Delivery and Performance Committee via the Integrated Performance Report. Version control of the document will also be introduced. The Primary Care GDS Commissioning Assurance Framework will be updated to reflect the revised Health Board Committee structure reporting arrangements and will include the performance metrics that are reported to the Delivery and Performance Committee via the Integrated Performance Report. Version control of the document will also be introduced.	Mar-24		Not yet due		Partially complete		CAF Dashboard, framework and tolerance level documents updated for 24/25 to reflect the revised Heatlh Board Committee structures and the current performance metrics. Will be approved as part of CAF assurnace documentation signoff at a future GDS meeting.					1	1491	Aug-24	Mar-24		
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R3	Management should undertake a review of IOSH training requirements as detailed in the Health & Safety policy, to determine which levels can reasonably be delivered by the Health Board. For the Working Safely level, management should consider whether any elements of the statutory and training modules will meet this requirement, negating the need for all staff to attend a one-day course, and update the Health & Safety policy accordingly.	Management will review the H&S training requirements, including the consideration of all training already available in the workplace and update the H&S policy accordingly	Jun-24		Not yet due		Partially complete		The training identified in the policy is being reviewed as part of a wider S+M review . This will indicat what H&S training is needed for each job role March 2024 training matrix and training needs analysis is being fianlised with the support of WOD and will be agreed by HSG in June 2024	None		Jun-24		#NUM!	1491	Aug-24	Jan-24		
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R4	Management should ensure that a training needs analysis is undertaken for all staff that use specialised machine tools. Once this has been completed management should then liaise with workforce to identify the courses that are available for staff to attend. In addition, management should ensure that a training needs analysis is undertaken for 'Key' Health & Safety Staff to ensure training requirements are identified and delivered	Management to undertake a training needs analysis for staff identified as 'Key' Health and Safety Staff to ensure training requirements are identified and delivered.	Mar-24		Not yet due		Partially complete		The Full TNA is being reviewed with WOD and the H&S team and departments. March 2024 TNA for for use of specialsit equipme t is being fianlsied and will be signed off by HSG in June	None		Jun-24		1	1491	Aug-24	Jan-24		
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R3	Senior management within Service Areas should ensure that: • Incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. A review is undertaken of the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. • The current reporting capabilities of the Datix system and the weekly monitoring efforts by the Quality and Safety Team are being exploited. • Datix reports of open/overdue incidents, incident reporting and management performance be shared and discussed within the governance structures of the Service Areas.	Services to provide an action plan for improvement to support how they intend to manage overdue incidents along with timely management of new incidents in line with the Incident Management Framework.	Mar-24		Not yet due		Partially complete		Weekly notifications sent to incident managers to manage incidents in compliance with IMF. Further reports provided to Executive Directors and Heads of service monthly to ensure opportunities to support timeline management.		Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation			5	1495	Aug-24	Jan-24		
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R4	Management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence.	Services to review systems in place to monitor lessons learned to support appropriate triangulation and improvement	May-24		Not yet due		Partially complete		reported locally through the service group led quality and safety forums. This is then reported through the Professional Nursing and Midwifery Oversight Group on a monthly basis. Progress on NRI/EWN/DoC					3	1495	Aug-24	Jan-24		
232417	Primary Care Dental Services - Management and Monitoring of General Dental Services Contract	Substantial	Director of Finance, Capital and Support Services	Assistant Director of Primary Care Services	R1	In the event of the GDS Monitoring Group meeting quoracy levels not being met, future meetings should proceed, and arrangements should be implemented to allow for any decisions undertaken to be approved/ratified outside of the meeting e.g. via Chairs action	Arrangements are in place to allow for decisions to be undertaken and approved outside of the meeting at Assistant Director, Interim Director of Finance, Chief Executive and Chair level, however this is not reflected in the GDS Monitoring Group Terms of Reference. The GDS Monitoring Group Terms of Reference will be updated to reflect this process.	Mar-24		Not yet due		Partially complete		TOR updated and will be formally signed off at GDS monitoring Group on 27th June 2024					1	1491	Aug-24	Mar-24		
232420	Estates Condition	Limited	Chief Executive Officer	Associate Director of Estates and Property/Director of Corporate Governance/Head of Estates/Head of Technical Services/Capital Programme Manager	R3	The THB should develop an Estates Strategy for the medium and long term, to be informed by the up to date Six Facet Estate Condition Survey.	PTHB Estates Strategy is being developed and is informed by the recent 6 Facet Survey with first draft to be produced in quarter one 2024/25	Jun-24	Mar-25	Not yet due		Partially complete		A draft Estates Strategy document has been progressed, however, the Consultancy appointed to undertake the 6 Facet Survey work, which is required to inform the document, has further quality checks on the output data to complete.	Significant organisation Transformation consideration underway making the 'where do we want to be' question uncertain in terms of the strategy		Target end of 2024/25 financial year		2	#NUM!	Aug-24	Mar-24		

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														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?							
232420	Estates Condition	Limited	Chief Executive Officer	Associate Director of Estates and Property/Director of Corporate Governance/Head of Estates/Head of Technical Services/Capital Programme Manager	R4	The Board should receive increased assurance on the risks associated with the absence of agreed funding to support the estates strategy, and the sufficiency of planned mitigating actions.	The challenges associated with limited Welsh Government, NHS funding are acknowledged, with significant organisational efforts being made to focus on sustainable services and financial efficiencies – this is led by clinical need but includes an understanding of associated estates matters. The current major capital investment business cases for Llandrindod phase 2 and North Powys Wellbeing Campus are progressing through the approval process and follow on from recent significant investments at Llandrindod phase 1 and Machynlleth. Any failures to secure proposed investments would be reported to Board along with mitigation measures, which may include more limited but targeted funding bids for improvement works, etc. The Estates Strategy draft document is being produced for Q1 2024/25 and will consider how the clinical need can be supported by a fit for purpose estate. If current funding ambition is not fulfilled, the process will need to flex to accommodate available capital investment. Action: the draft Estates Strategy will provide an assessment on the funding and affordability risk of any estate related proposals – this will be informed by the outcomes of the recently introduced Welsh Government Capital Prioritisation Process which will be implemented in April 2024	Jun-24	Oct-22	Not yet due		Partially complete		Major project funding applications/business cases for Llandrindod Phase 2 and North Powys have been submitted to Welsh Government and are under scrutiny, with decisions anticipated in August 2024. Should these schemes receive approval, PTHB will be meeting the planned programme targets and there will be no shortfall in funding. Note added August 2024 - the latest feedback from Welsh Government is that the capital prioritisation findings should become known end September/October 2024					2	22	Aug-24	Mar-24		
232420	Estates Condition	Limited	Chief Executive Officer	Associate Director of Estates and Property/Director of Corporate Governance/Head of Estates/Head of Technical Services/Capital Programme Manager	R5	The THB should develop alternate plans to mitigate the risk of the revenue support needed in the estate over the short-medium and long term	The overall strategy to improve the condition of the estate (and reduce backlog maintenance) includes significant improvements and modernisation associated with major project investments and is further complimented through discretionary capital, EFAB, SBARs, Re:fit, RPB related HCF and IRCF capital investments, etc. The development of the Estates Strategy alongside opportunities from implementing agile working, ongoing estates rationalisation activity, RPB Strategic Capital Plan opportunities, etc. will determine the future scale and nature of the built estate, and positively impact the factors raised by this audit. The Estates department operates a risk based maintenance approach for the aged and significantly dispersed property portfolio, and is continually seeking ways to improve the service within resource limits. This currently includes, for example, setting up a staff hub centrally in Llandrindod, to complement the current bases in Brecon and Newtown; this will go some way towards addressing the 20-25% travel time challenge. Further opportunities will continue to be investigated. Draft Estates Strategy to be produced for consultation in Quarter 1 of 2024/25 which will include an updated backlog maintenance assessment and provide a framework for re-assessing the associated resource and revenue position.	Jun-24		Not yet due		Partially complete		Capital investment is key to the continued work to improve the condition of the estate and ease the burden on the Estates team. The Health Board has been sucessful in securing an addional £3.2M in June 2024 which is specifically targeted for Backlog Maintenance improvements. Continued improvements in the governance and management of Estates Compliance are proving effective in supporting the risk-based approach to estates management. Further significant capital business case submissions are currently with Welsh Government for scrutiny.					2	1495	Aug-24	Mar-24		
232420	Estates Condition	Limited	Chief Executive Officer	Associate Director of Estates and Property/Director of Corporate Governance/Head of Estates/Head of Technical Services/Capital Programme Manager	6	The Board Assurance Strategy will reflect the current position and provide assurances to the Board on the effectiveness of the identified actions to mitigate/tolerate the Capital Asset risks	The risks associated with Estates are recognised under CRR009 in relation to a 'fit for purpose' estate in the Corporate Risk Register and cover a number of areas of activity and statutory compliance – the risk rating was 20 and is currently 16. The details for the constituent elements are reported via an established assurance meeting structure and specifically highlighted periodically at Committee. As identified in the report, any specific escalation of risk (e.g., management structure for 'fire') is brought forward for focus as a separate CRR item until closed. A specific discussion to consider and review the approach to risks managed as part of the capital and estates function will be considered in Delivery and Performance Committee.	Jul-24		Not yet due		Partially complete		Paper being prepared for consideration at D&P Committee which outlines the capital position and associated risks					1	1495	Aug-24	Mar-24		
242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health	Head of Public Health Programmes and Projects/Assitant Head of Public Health Nursing	R1	a) Planning should start with the most up to date primary data. b)The population totals should be agreed at a fixed point in time. c)Population changes should be recorded, and clear auditable trails established. d)Check balances should be embedded to ensure accuracy. e)Spreadsheets should have Standard Operating Procedures to ensure consistency, protection, owner oversight, review periods, and retention	Planning always starts with the most up to date primary data provided by our information team which is based on the planning assumptions provided by VPW. • Population totals will be fixed at the time that the final JCVI advice is given to Health Boards, however before the advice is announced (usually a few weeks before the campaign) the planning assumptions change multiple times requiring multiple planning scenarios. • VPW Planning Assumptions and JCVI advice inform the population changes, however we can record these going forward on the front page of the spreadsheets along with a SOP to ensure consistency, protection, owner oversight, review periods and retention. • Because of the nature of the vaccination programme, population and planning changes with each campaign which means a new plan needs to be produced for each campaign. Action: Develop a SOP and front sheet for the spreadsheet as per recommendations 1.1a-e to ensure consistency	Aug-24		Not yet due		Partially complete		Front sheet for the spreadsheet completed and being implemented. SOP to be confirmed. Primary data is dependant on confirmation of eligibility criteria being published by JCVI and subsequent WHC from WG. Leading up to the publication draft scenarios will be developed and modelled on likely eligibility groups. SOP will be developed as part of this action. **19-08-24** - We only have indicative numbers for the Covid-19 programme as of August 2024 that we currently use for capacity planning. This is noted at the front of the spreadsheet. A data refresh is planned by DHCW on or before 1st Sept. Once we have notification that this is completed a final capacity planning document can be completed for Powys	Late confirmation of JCVI recommendation impacts on planning time **19-08-24** - The awaiting of the data refresh by DHCW. But this does not hinder the planning .	Regular communciation with NHS Executive Vaccine Planning Team on potential announcement of JCVI and current planning assumptions.	Aug-24				Aug-24	Jun-24		
242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health	Head of Public Health Programmes and Projects	R2	2.1a) Communications with Schools should also extend to Governors, increasing the level of school oversight. 2.1b) PTHB expert data protection advice should be sought to help overcome objections. 2.1c) Controls procedures are agreed that ensure all communications reflect the most up to date information. 2.1d) The procedure has an owner, reviewer, appropriate review periods and is communicated to all participating parties.	2.1a & C) **Action**: Develop overarching communication strategy and action plan to cover all vaccinations 2.1b) Escalation has already commenced to address the issues currently experienced with accessing class lists and parent/carer contact details. Should there be a delay in the sign off of the ISP by the Local Authority, consideration will be given to communicating with school governors. **Action:** This is being actioned through the development of an ISP and is awaiting final sign off by the local authority Sept 2024 Ongoing Sarah Barnes, Head of Service: Public Health Programmes & Projects Wendy Day, Assistant Head of Public Health Nursing 2.1d) **Action:** Recent review of the Standard Operating Procedure has been completed and will next be due for review in January 2027. The procedure has an owner, reviewer, appropriate review periods and is communicated to all participating parties.	Sep-24		Not yet due		Partially complete		An overarching Local comms plan is being developed for all vaccinations and will incoporate the Winter Respiratory Vaccination Programme. A draft National Comms Plan is currently out for comment from VPDP who are leading on the National Comms. Actions from the National Comms Plan will be included in the Local Comms Plan. Further specific comms with schools will be devloped **19-08-2024** - no change to this action. Comms plans will be discussed at ODG 22 August and PVG in Sept.	More time required to develop the Comms Plan to incorporate all programmes	WRVP plans are discussed at the monthly HB Vaccination Operational Delivery Group. All members have been asked to develop their Action plans by end June. Any commimocations required and identified can be included in the Comms plan.	Final sign off at Powys Vaccination Group in early Sept				Aug-24	Jun-24		
242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health	Head of Public Health Programmes and Projects	R3	The VODG should have an overarching SOP bringing together all reporting functions. SOP should be written for each reporting function and linked into 3.1a. 3.2a) Committee Terms of Reference should be clearly defined, authorised, and include a defined quorum for key participants. 3.2b) Actions should be clearly flagged, have an owner, delivery timeline, and a clear audit trail to the Action log. Closed actions should be linked to the appropriate minutes. 3.2c) Final minutes should be retained in PDF format in a secure folder.	3.1)Action: SOP for the Vaccination ODG and the Powys Vaccination Group to be developed. 3.2)The governance structure for the VODG (monthly) and PVG (Quarterly) has been developed. ToR have been written and agreed for each group. There are escalating processes in place to manage risks and issues. Project groups for each vaccination programme will be established prior to the start of the Winter Respiratory Programme and will report to the VODG initially and PVG and plans submitted to Executive Committee and Board for final approval/information. Action: Review all SOPs and processes for the groups e.g. Risk Management, ensuring remain fit for purpose. Action: Review all processes for information management as per 3.2a-c June 2024	Jun-24		Not yet due		Partially complete		Final TORs for Powys Vaccination Group and Operational Delivery Group in place. Draft overarching document/SOP being developed,and risk /issues log reviewed on 4th June 2024 and being aligned to corproate templates. On track for end of June. **19-08-2024** - A draft overarching SOP has been developed and will be discussed at the PVG in Sept.		There are currently agreed ToR for both the PVG and ODG and both groups are aware of the interactions between them	Final sign off at PVG in early Sept				Aug-24	Jun-24		
242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health	Head of Public Health Programmes and Projects	R4	4.1a) Risk management should follow a PTHB standard framework and include seeking expert advice when necessary. For example, consulting with the SES before hiring premises. 4.1b) The register should have an owner and periodic review date. 4.1c)The register should be included in the reporting cycle at the appropriate level.	In response to the recommendations in 4.1a the Vaccination Service will check with the Health & Safety team whether a Licence Agreement needs to be in place for short term venues e.g. for 5 days. Winter Respiratory Vaccination Programme Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 16 • The Vaccination service needs to be agile and respond quickly to offer vaccination to protect the public from infectious diseases. Requesting other busy departments such as the Estates Team to source non�Healthcare venues could slow down processes particularity when short window for vaccinations. **Action**: Raise with the Health & Safety team and determine the correct processes to follow for Risk Assessment and document checking for external venues. Action: Escalate the points raised above to the Health & Safety Committee if findings have a n impact on the service or wider organisation activity	Jun-24		Not yet due		Partially complete		This was discussed at the HB Health & Safety meeting of 17 June 2024 and their advice is that Vaccination Service does not need a Licence Agreement to be in place for short term venues. Next steps for Vaccination Service is to review short term venue hire checklist and ensure that venues being hired supply their approprate risk assessments to HB (e.g. fire risk assessment). **19-08-2024** - Advice received from Health & Safety team and Vaccination service and incorporated in to our protocols.	NA	Risk Assessments have been done for every community setting visited.	July ODG	Yes, Health & Safety Group Minutes of 17 June 2024.			Aug-24	Jun-24	Yes, ready for closure	action completed

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242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health		R5	5.1a) Data should be accessed to track and plan progress against the stated aim for increased dual vaccination. 5.1b) Regular updates should be included in the reporting hierarchy.	Note: • The vaccination programme in PTHB can only offer co-administration of COVID and flu vaccination to PTHB staff. All other flu vaccinations are administered in primary care and are recorded on primary care systems which the Health Board is not able to access. Winter Respiratory Vaccination Programme Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 18 • Anecdotal qualitative feedback from primary care providers has been that patients do not want both vaccines together- this is mirrored in the feedback we have received from staff attending the vaccination centres for their winter respiratory vaccines. • We can ask the information team to provide this data for us on any coadministration which takes place in our vaccination centres, however, we have not been asked by VPW to report on this. Action: To review this, ask for 24/25 and to aim to develop plans that support co-administration	Sep-24		Not yet due		No progress		Until the final JCVI recommendations are issued it is challenging to plan for dual vaccination. Once the recommendations are issued dual vaccination can be included in the plan if operationally possible. **19-08-2024** - WRVP WHC was published 02 August 2024. The WHC states that 'Co-admin of Covid-19 and the flu vaccines should occur where effective and efficient to do so'. Our only opportunity to co-administer Covid-19 and flu is when GP participates in the Covid-19 programme or when delivering staff flu (although Health and Social Care staff are not a priority group for Covid-19 this year). Six GP practices have expressed an interest to vaccinate Covid-19. The same issues with Data systems and surveillance of co-administration are ongoing	Delay in JCVI statement. Issues with DHCW data	Regular communciation with VPW on potential announcement of JCVI and current planning assumptions.	Final sign off at PVG in early Sept				Aug-24	Jun-24		
242504	Follow Up Welsh Language Standards	Reasonable	Director of People and Culture	Service Improvement Manager Welsh Language & Equalities	R1	The Welsh Language Department should remind all Welsh Language Standards Service Leads of their responsibility to attend the WLS Group meetings. If they are unable to attend, then they should ensure that an appropriate member of the department attends instead. The Terms of Reference of the WLS Group should be updated to reflect the change in Executive Director responsibility for Welsh Language and then formally approved by the Group. The Welsh Language Department should issue a reminder to those Services that are yet to submit an updated Welsh Language Standards action plan of the requirement to do so with a suggested deadline. The Welsh Language Department should also consider enhancing the information recorded on the 'Action Plan' Log to note when updated Service Action Plans are received or if they are advised that there are no changes. Management may also consider reviewing this action plan at the WLS Group meetings. The Welsh Language Department should also consider scheduling individual meetings with the Welsh Language Service Leads prior to the WLS Group meetings. The meetings would allow an opportunity for the Service Leads to update the Welsh Language Department on any issues regarding the Welsh Language Standards for their Medium Follow-up: Welsh Language Standards Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 7 service and also allow for the review of the actual action plan. It is acknowledged that in some cases a meeting may not always be required but the scheduling of the meetings could act as a prompt for the Service Leads to provide an update to the Welsh Language Department	he Welsh Language department will remind Welsh Language service leads that it is their responsibility to attend WLS Group meetings, and to submit an appropriate action plan. September 2024 Service Lead for Welsh Language 2 The Welsh Language Service Lead and Director of Workforce & OD have reviewed the ToR for the WLS Group meetings. Completed Service Lead for Welsh Language / Director of Workforce & Culture 3 The Welsh Language department have simplified the monitoring processes and will maintain the new documents centrally. This will include a place to note how recently an update has been received, or a notice that no update is required. Ongoing Service Lead for Welsh Language 4 All WLS Group members will be reminded of their ability to arrange 1:1 meetings as required; these will be scheduled where there is a need for enhanced scrutiny e.g. during a Welsh Language Commissioner's Investigation.	Sep-24		Not yet due		No progress									Aug-24	Jun-24		
242504	Follow Up Welsh Language Standards	Reasonable	Director of People and Culture	Service Improvement Manager Welsh Language & Equalities	R2	All Welsh Language Service Leads should be reminded to ensure that Welsh Language Standards Compliance to be included as an agenda item at an appropriate management meeting. Re attendance at WLS Group, please see recommendation 1 above. Management should consider implementing version control for each occasion that the Standards Monitoring Document is updated.	1 Prior to the WLS Service Leads Group meeting in March members were reminded to ensure that Standards compliance should be a standing agenda item; some departments have responded to confirm that this is the case. Completed Service Lead for Welsh Language 2 See above. See Above Service Lead for Welsh Language 3 Version control has been implemented on the standards monitoring document.			Not yet due		No progress									Aug-24	Jun-24		
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Executive Director of Allied Health Professions, Health Sciences and Digital/Director of Corporate Governance / Associate Director of Estates, Facilities and Support Services/Head of Technical Services	R1	1.1) The THB should review current assignment of decarbonisation responsibilities, and capacity to deliver the same. 1.2) The decarbonisation governance structure, including key roles, forums and reporting lines, should be documented in an organogram. 1.3) ESG attendance should be promoted to ensure directorates and sub-groups are appropriately represented wherever possible. 1.4) Sub-groups should ensure that exception reports are submitted to ESG where necessary e.g. when there is a risk to delivery of their assigned actions from the DAP	The recommendation is agreed, and decarb responsibilities will be clarified under the current restructure with resource levels remaining unchanged. August 2024 Associate Director of Capital, Estates & Property 1.2 The recommendation is agreed, an organogram will be produced in line with the structure and reporting lines illustrated. August 2024 Head of Technical Services Decarbonisation Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 16 1.3 The recommendation is noted. Attendance at Environment and Sustainability Group will continue to be monitored, with the ambition to continue to widen and strengthen meeting membership across the organisation post reorganisation. September 2024 Head of Technical Services 1.4 The recommendation is agreed. Consistent implementation of exception reporting from the key subgroups will be applied.	Aug-24		Not yet due		No progress									Aug-24	Jun-24		
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R4	The DAP should incorporate known and estimated costs, where relevant	The recommendation is agreed. PTHB will utilise estimated costs from the recent Six Facet Survey in addition to the High Level Assessment undertaken by Re:fit to add costs to the Decarbonisation Action Plan. This work will help inform the funding strategy.	Nov-24		Not yet due		No progress									Aug-24	Jun-24		
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R5	The quarterly DCR returns should be retrospectively shared at an appropriate forum, e.g. IEG, recognising the timeframe does not allow for sharing and approval before submission. 5.2 At the DCR quarterly returns, actions should be RAG rated as required by the DCR team. 5.3 The THB should liaise with NWSSP to ascertain the current timeline for delivery of "Approach to Healthcare" actions 44.2 and 45.2	The recommendation is agreed. The latest DCR return was retrospectively shared with the April 2024 Innovative Environments Group and will continue to be shared at future meetings. n/a Actioned since audit fieldwork 5.2 The recommendation is noted. The Health Board has consistently used the same reporting approach during the submissions, which have been accepted by the DCR team. The Health Board will work with DCR team to review guidance in respect to 'past deadline' initiatives. However, in line with DCR guidelines, deadlines are financial year targets and none were past their respective deadline during last DCR submission (2023 Q4). August 2024 Head of Technical Services Decarbonisation Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 23 5.3 The Health Board will liaise with NWSSP for timeline for delivery of Approach to Healthcare actions 44.2 and 45.3. Requests for updates have been made and a 'Request For Change' has been submitted to HSCCE Programme Board (scheduled for 8 May) for a number of initiatives, including Initiative 44 and this will give greater clarity for submissions.	Aug-24		Not yet due		No progress									Aug-24	Jun-24		
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R6	Further data analysis should be performed on the carbon reductions achieved to date against the baseline year, and on the future reductions forecast, to better understand the specific areas in which these savings will be achieved, and whether these are sustainable year on year. This information should be factored into the assurance provided to IEG/Board.	Carbon reduction data is reliant on a number of factors and is taken from a number of sources. The data sets continue to improve as understanding of the complex elements contributing to the calculations are better understood. One of the contradictory influences arises from capital investment in project activity, for example, Machynlleth hospital gave rise to a 'spike' in the reported carbon data for the period in which construction took place, whilst the project itself will deliver decarbonisation benefits for many years to come (solar photovoltaic, electric vehicle charging, insulation upgrade, triple glazing, etc.). Procurement data contributes over 60% of the carbon impacts for the organisation and the data has changed and evolved significantly over recent years. NWSSP-Procurement are making changes to their reporting which will take account of scope 3 indirect supply chain reporting and will continue to evolve. The Health Board decarbonisation roadmap is heavily reliant on delivery from Re:fit programme, whose Investment Grade Proposal is offering guaranteed 12.6% sustained carbon reductions. The step change in emissions will enable progress towards the 2030 net zero emission reduction targets. The recommendation is agreed. The team will continue to interrogate data and provide assurance to IEG/Board on the emission reporting data, recognising the challenges with the stability and complexity of the data gathering process.	Nov-24		Not yet due		No progress									Aug-24	Jun-24		

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242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services/Head of Capital	R7	Post-project reviews should be undertaken, where feasible, on completed decarbonisation-related projects, to assess whether the forecast benefits have been achieved. Lessons learnt should be shared to inform future investment decisions in decarbonisation.	The recommendation is noted, and the Health Board will look to expand the inclusion of decarbonisation benefits realisation within all major capital projects. It is expectation that funding from Welsh Government is evaluated against decarbonisation targets and so this recommendation will close the loop on evaluating delivery against decarbonisation initiatives following project completion.	Q4 2024		Not yet due		No progress									Aug-24	Jun-24		
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assitant Director of Complex Care/Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home Governance/Finance Team	R4	Management should review the processes in place within both teams for the approval and application of annual inflationary increases in order to standardise the processes to be followed. Management may wish to consider producing a local 'desktop' procedure that sets out actions/processes to be followed for updating the NCC database.	Focussed work on annual uplifts has commenced with finance colleagues and there is a shared objective to improve the health board approach around this. We will give full consideration to improvements and timely updates on the NCCD database as part of the service review	31.12.24		Not yet due		Partially complete		**Aug 24** - Significant progress around annual uplift process and this work with the Finance team continues.							Aug-24	Jul-24		
242507	Patient Experience (Final Report)	Reasonable	Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality and Safety	R1	The patient experience strategy should be formally reviewed to ensure that it adequately covers all required matters.	Recommendation accepted. Review PEP 007 'Powys Patient Experience Strategy 2016 – 2019' and consider updating in line with Welsh Government Framework and Quality & Engagement (Wales) Act 2020.	Apr-25		Not yet due		No progress									Aug-24	Jul-24		
242507	Patient Experience (Final Report)	Reasonable	Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality and Safety	R2	Further work is required to identify how the low patient experience response rates can be improved and then roll out the lessons learnt to be applied consistently to all service areas.	Recommendation accepted. Continue to ensure response rates to CIVICA surveys are considered within service meetings, Patient Experience Group along with Patient Experience Quality & Safety Committee. With a continuous focus of improvement to address variation in the way feedback is obtained recognising marginal groups and digital poverty. Sharing of learning from across services regarding increased response 'hot spots to ensure consistency across the organisation.	30.09.24		Not yet due		No progress									Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R1	The Risk Management Framework and Risk Management Toolkit should be reviewed in accordance with their stated version control requirements to ensure that their content is current, and in alignment with organisational strategic objectives.	The Risk Management Framework and Risk Management Toolkit will be revised as recommended.	30.09.24		Not yet due		Partially complete		**August 2024** - Staff now in post, review has commenced and due to be reported to the Board in November 2024. Date extension requested to 30 Nov 2024							Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R2	Promotion of risk management should be undertaken to ensure that all Health Board staff are aware of their roles and responsibilities, and a rolling programme of risk management training introduced to maximise their understanding and application of the contents of the Risk Management Toolkit.	A programme of risk management training and awareness will be developed and roll out will commence by 30 October 2024.	30.10.2024		Not yet due		Partially complete		**August 2024 -** risk management training being reviewed and updated ready to commence roll out by end Oct 2024							Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Medical Director	Head of Primary Care Medicines Management/Head of Community Serivces/Senior Pharmacist High Cost Drugs/Formulary	R3	Formal Processes should be established within the Medicines Management department, and Medical Directors Office to ensure regular review and formal reporting of their respective risk registers, and their collegiate risk issues as a whole. This would also provide an assurance mechanism that those high scoring risks that can't be managed at departmental and Directorate levels can be discussed, and then escalated if appropriate to the Corporate risk register in a formal and structured manner.	Medicines Management/Pharmacy service leads to ensure that all Medicines Management/Pharmacy risks are reviewed on a monthly basis and that the risk register is updated as appropriate, initialled and dated. Risk register to be a quarterly standing agenda item on the senior pharmacist meeting agenda. Formal quarterly meeting between Medical Director and Chief Pharmacist in place to go through Medicines Management/Pharmacy Risk Register to ensure that a risks are escalated to RAG as appropriate.			Not yet due		No progress									Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Executive Director of Nursing, Quality, Women & Childrens	Assistant Director Women and Children	R4	All risks stated on the risk register should be reviewed in accordance with a prescribed review timescale that is commensurate to the level of risk scoring. Risks should also be supported by a brief narrative to state action to be undertaken to mitigate each risk, a proposed timescale for completion if practicable, and an action progress update provided during each review undertaken.	Risk registers will be reviewed and updated within the monthly Women & Children Quality & Performance meeting, to ensure timely updates and escalation as required	30/07/2024		Not yet due		No progress									Aug-24	Jul-24		
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Director of Corporate Governance	R6	Ongoing action should be taken to ensure that the BAF is populated as detailed within the covering paper presented to the May 2024 Board meeting. Furthermore, the BAF should then be subject to ongoing progress reporting to the Audit Risk & Assurance Committee and the Board.	The development of the BAF forms part of the scheduled work programme and forms part of the Board work programme for the Boards meeting on the 25 September 2024.	30/09/2024		Not yet due		Partially complete		**August 2024** - as planned, next stage of BAF scheduled for the September 2024 Board							Aug-24	Jul-24		

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No. Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending	When will implementation be achieved?	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Planning & Performance Director of Finance and IT & Director of Primary, Community and Mental Health Services Director of Nursing	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC. 2.3 The CHC Standard Operating Procedures should be aligned with the Scheme of Delegation (Section 12) and practices in Adult and MH&LD CHC should be aligned. The CHC SOP should also be updated to clarify when contract renewals valued over £50,000 p.a. should go through a High Cost Resource Panel. 2.4 The health board should ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for CHC packages across Adult and Mental Health Nursing.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned to be 3-6 months long and commenced in early November 2019. Once the recommendations and/or revised Scheme of Delegation is issued the health board will undertake a review focusing on the recommendations of this report 2.3 CHC Standard Operating Procedure to be updated to ensure the all cases over £50,000 are referred to High Cost Panel 2.4 Formal communication to be issued from the Director of Finance to services leads for CHC (Adult and Mental Health) on the need to ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for all CHC packages. Additionally, to offer support if clarity is required on the Scheme of Delegation or SOP.	Dec-20		Overdue	2	Partially complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of contracts, Standard Operating Procedures and Scheme of Delegation. This action will be transferred to the Programme's risk register to track to completion. **28/2/2022** Complex Care Project has commenced with Secondment to lead the work and review the requirements in line with the New Framework which is being implemented. Scheme of delegation and sign off procedures are in place and effective. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **06/04/23** - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group **07.02.2024** - S33 group has not been functioning Manager finishing in March. Scheme of delegation has been completed and agreed, however, will now be reviewed under new strategic structure SOP has been updated and agreed in July 2022, scheme of delegation will be added as an amendment. New internal audit underway for CHC working with new Assistant Director in Complex Care	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	Sep-21		43	1495	Aug-24			
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent inspectorate visits and feedback from the relevant local authority. 3.2 This process should be documented in the CHC SOP (see finding 4 also). In-county care homes monitoring 3.3 The health board should clarify how it receives assurance that the LA has escalated issues identified through the joint monitoring process to the JQAP as appropriate, for example through its representation at the JIMP and JQAP meetings and through feedback to the CCSG. 3.4 The health board's CHC SOP should be updated to make reference to the joint monitoring process under the S33 agreement, including the assurance it receives as per 3.3 (see finding 4 also). 3.5 The above recommendations on in- and out-of-county care homes monitoring should take into consideration the NHS Wales National Collaborative Commissioning Unit project on provider care map dashboards. 3.6 The assurance mechanisms over CHC and FNC packages, including for monitoring both in- and out-of-county care homes, should be incorporated into the Board Assurance Framework. Funded Nursing Care 3.7 The health board should be clear on how it receives assurance over the timeliness and accuracy of the FNC payments to the care homes. This should be documented in the SOP. 3.8 Management should ensure that issues relating to the care homes S33 agreement, including FNC, are escalated to an appropriate level, both with the Local Authority and within the health board. The LA should be reminded that health board approval is obtained on care requirements prior to funding being committed.	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	Apr-20	Jul-21	Overdue	2	Partially complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart for ensuring payment is made. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of checklists, quality dashboard and SOPs. This action will be transferred to the Programme's risk register to track to completion. **28/2/2022** - Escalation of care homes is supporrted via the local Care Home MDT. Assurance checkes part of the QA assessment for out of county placements in place. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **07.02.2024** - Monitoring for out of counties is completedby the main commissioning body for that area. PTHB adhere to governance by reviewing with the area LA and HB or CCG prior to placment. This is also added in to each patients QA documentation. JIMP is a collaborative meeting. Any issues raised are reported via QSEG, CSG by reports completed. Out of county reviews are completed as per National CHC Framework 3/12 and annually. These are then brought back to panel for scrutiny. FNC Payments are completed by finance. Reconciliation is completed by the Complex Care adult general admin under Section 33.	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	Jul-21		51	36	Aug-24			
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit. 4.2 The health board should undertake a demand and capacity review in light of the updated processes, in order to ensure compliance with legislation and maintain patient safety.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes. 07.02.2024 Current SOP evidences scheme of delegation, will now be updated to reflect new structure. Processes within adault general and MH/LD are aligned with the development of the same QA document, governance processes. Demand and capacity review has been undertaken and reported to in August 2022	Mar-20	Apr-21	Overdue	2	Partially complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 As part of the restructure of the team in CSG betweeen November 2021and January 2022 the service was re mapped against activity and new pathways and a revised service model was implemented. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **06/04/23** - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group **07.02.2024** - AD for Complex Care appointed and undertaking a gap analysis. DDoN undertaking a review of governance arrangements for Complex Care withe new AD.	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion, reviews completed virtually	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21		52	39	Aug-24			
192022	Outpatients Planned Activity	Reasonable	Director of Performance and Commissioning		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access Policy within the health board will be developed that details roles and responsibilities and sets out the general principles and rules for managing patients through their elective care pathway. WG are currently reviewing national waiting times standards (RTT) in light of COVID19 19 and the impact of new ways of	Mar-21	Mar-22	Overdue	3	Partially complete		This work has been delayed due to covid but also now needs to be considered in line with national guidance on pathways and the Powys renewal priorities. This will take until end of the year. This work is now further delayed due to the required Health Board adoption of Care Pathways. A revised policy document will aim to be completed by Nov 24	Waiting for overall WG rollout. See earlier comment	Adopt treat in turn methodology and adherence to extant all Wales access policy	Jun-23		24	12	Apr-23	Sep-20	NO	PTHB needs an over-arching Access Policy so the action needs to stay open. Aim for a draft policy to be written by March 24.
202115	Winter pressures and flow management	Reasonable	Director of Primary Care, Community and Mental Health	Senior Manager Unscheduled Care	R2	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update process.	2.1 Agree – cannot action until further consultation. Recent engagement with DU has suggested DTOC will return by end of year. If this is the case policies and procedures will need recommencing & revision if required. 2.2 Flow charts & diagrams of discharge requirements circulated to staff, placed in shared access folders and discussed in team meeting. Will be a standard agenda for assurance of understanding & interpretation by staff. 2.3 The update of any policies will be in line with Welsh Government direction on DTOC and discharge planning, so we are working within national guidelines.	Mar-22		Overdue		Partially complete		Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements. **Nov 2023**- DTOC system now revised to Pathways of Care Monitoring. PTHB has been reporting on a monthly Census since April 2023 and working with the delivery unit through regular action planning. Patient pathways are embedded on admission. National guidelines for discharge have been published, PTHB local discharge guidelines under review- to work with our partners in development with aim of completion by end of January 2024. 31/1 The reluctant to leave procedure and discharge guidelines have been circulated for comment. The discharge hospital guidance has been revised but pending an addition of the choice element TBC by WG. Delivery Unit confirmed this will be released soon. Both procedures are in line with Welsh Government guidance released in November **27/3/2024** - Management of relcutant to leave published. Discharge guidance for PTHB In draft & ready to be circulated once choice element has been published by Welsh Government. Confirmation from NHS exec this will be due "soon".	Choice element needs to be added for discahrge guidance, WG advised due soon. As an interim discahrge guidance has been completed in anticapation of adding the choice element	Mitigated with the pathways of care discharge guidance being followed. Cannot implement local choice, should be guided nationally. As an interim Pathway of Care Discharge National Guidance to be followed, ESR training availbale and Mannagement of Reclutant to Leave to be followed	**01/02/2024** - Relucant to leave **28/2/24** - Discharge guidance **27/3/24** - Discharge guidance due "soon" is the update from NHS exec, hopefully early Spring. Once released will circulate internal discharge guidance for approval & release. Draft compelte.	https://nhswales365-my.sharepoint.com/:w:/r/personal/claudia_oshea_wales_nhs_uk/Documents/The%20Management%20OF%20Reluctant%20Dischar	28	1495	Aug-24		NO	
212207	Dementia Services- Home Treatment Teams	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health Services	R1	The operating environment within both teams needs further evaluation, to ensure clients have consistent access to services throughout the Health Board and good practice can be shared and embedded.	The configuration of the North Powys team to match the clinical specialism of the South will require additional funding, as well as any move to the South Team matching the North's 7-Day working practices. Elements of this funding will be considered as part of the Mental Health Service Improvement funding and any additional funding released by Welsh Government.	Sep-22		Overdue	Low	No progress		There is still no funding to enable the expansion of the team to accommodate 7 day working. This will be considered within the overall MH model of care through the MH Transformation work now known as 'Better Together'. Some delays in progress have occurred as a result of the need to reprioritise the implementation of 111 press 2 in line with Welsh Government timescales. This service went live in 2023 but the ASM programme requires appointment of a Transformation Programme Manager, recruitment of which is underway. The eventual model will be incorporated into our OBC	Additional financial resources and reconfiguration of older adult services are required in order to operate the service on 7 day basis.	Should patients deteriorate over weekend, inpatient and MHA processes are available.	7 day working for the DHTT will be considered as part of the Mental Health transformation work. Completion date will exceed the agreed deadline for this action.	Jun-23	23	1495	Aug-24	Jan-22		
212207	Dementia Services- Home Treatment Teams	Reasonable	Director of Primary Care, Community and Mental Health	Operations Manager, Mental Health Services	R2	The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee.Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the operational updating of the WCCIS System.	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 – day basis we will require two flow charts demonstration patient flow and the method of referral.The SOP requires finalisation and until full expansion of the service will require two sections, relating to North and South Powys. This will include an update on WCCIS forms to be utilised, however, it should be noted that this work is conducted on an all-Wales basis and all agencies using WCCIS are required to agree to the same forms and processes.	Apr-22		Overdue		Partially complete		Strong progress has been made on the SOP, and updating WCCIS forms is underway. However, these need to be agreed at a national level before they are implemented. Authorisation still awaited. Update: the SOP is complete but the Policy in place will need to be updated again in line with the outcomes of work through the Better Together ASM programme to reflect consistency for a Pan Powys model	Need for Policy to reflect a Pan Powys approach rather than having sub SOPs for the two pathways of North and South. This action should therefore remain in the aidt recs tracker until complete.			Jun-23	28	1495	Aug-24	Jan-22		
222311	North Powys Wellbeing Programme	Reasonable	Associate Director of Capital, Estates and Property	Senior Responsible Officer	R5	An updated benefit framework should be developed to ensure clarity and relevance to the phase of the Programme but most importantly to meet with the overall desired outcome of the North Powys Wellbeing Programme	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	Dec-23		Overdue		Partially complete		Transformation element of the programme was transferred to transformation and value team under ASM for a period. Further work progressed via RIBA 1 to inform facility planning however the outputs of this have not been incoporated into an overaching benefits and outcomes framework due to limited capacity within the time. Team members are back with the programme and work is now being undertaken to develop further the detailed models of care, workforce and financial implications. Benefits and outcomes will be developed per service areas in the autumn and an overarching framework will be put in place with baselines and trajectories.					8	1495	Aug-24	Jan-23		
222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Assistant Director of Therapies and Health Science	R3	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	Oct-23		Deadline Revised		Partially complete		Meeting held with WOD 28.03.2023 - recruitment process and ESR capability to be looked into further to support achievement of this recommendation. **November 2023:** WOD engagement with ESR team and NWSSP regarding potential to strengthen process through existing TRAC/ESR systems. Delayed meeting due to WOD/NWSSP capacity but re-engaged Nov 2023 and meeting planned. Deadline revised to reflect this. **July 2024:** No progress on this action following secondment of Deputy Director of AHPs & HS for first half of 2024. Reengagement with WOD required.					9	1495	Aug-24	Mar-23		

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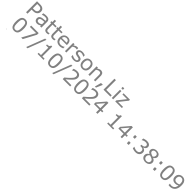
PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No. Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending	When will implementation be achieved?	If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
222321	Performance Management and Reporting	Substantial	Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	R1	Ensure that the Integrated Performance Framework has been fully implemented as planned and is operating effectively.	PTHB has established an IPF implementation group and developed a project implementation plan with the aim of integration by the end of Q3. Key areas of implementation include but are not limited to. • Power BI Performance and assurance dashboard • Performance reporting (Commissioner and Provider assurance framework, Integrated Performance Report, Directorate performance reviews, and Performance and Engagement for key services).	Dec-23		Overdue		Partially complete		Implementation of the IPF, approved in September 2022, has been taken forward: - Directorate Performance reviews refreshed and structured around the 4 domains of the IPF. - Integrated Performance Report refreshed to provide more detailed narrative on escalations and exceptions, performance trajectories and mitigating actions to ensure performance targets achieved. - Performance and Business meeting established to provide regular forum for discussion with the services on performance across the 4 domains of the IPF. Further work to be taken forward as agreed by the executive team, to further embed the Duty of Quality within the PBM and IPF structure. - Work continues on the Power BI supporting solution however is behind timescale. The supporting IT solution has not prevented the rollout of the IPF.		The health board is still able to deliver a performance function without the IT solution. A revised timescale for the IT solution is being developed for Executive committee in July 24			8	1495	Aug-24			
232401	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	David Farnsworth/Chris Moss	R1	Procedural documentation should be developed which sets out in detail how actions regarding In-reach Medical Staff should be undertaken by the Health Board's staff.	Develop Standard Operating Procedure setting out in detail how actions regarding in-reach medical staff should be undertaken. This will include an information pack of PTHB policies and procedures for visiting consultants. Develop process/procedure for development of a Service Level Agreement.	Nov-23		Overdue		Partially complete		SOPs in process of being revised, but behind original deadline. SLAs in process of being revised and updated by the Head of Commissioning and to be presented to the Executive Team for approval. **20/3/2024** - SLA template updated for 2024/25 and to be presented along with updated LTA template to Executive Team.					9	1495	Aug-24			
232403	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R3	SLAs should be signed off with all providers of In-reach Medical Staff on a timely basis.	To ensure that all agreements signed within financial year. Aim to have timelier sign off of agreements with NHSE providers.	Sep-23		Overdue		Partially complete		All SLAs with Welsh providers have been signed for 24/25. Work ongoing to sign the 24/25 SLAs with English providers.					11	1495	Aug-24			
232404	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R4	The frequency of meetings should be reviewed to determine what is appropriate to reflect the level of risk for each provider of In-reach Medical Staff and this should then be reflected in the SLAs. Following this, Contract Quality Performance and Review Meetings should be held in line with the frequency specified in the SLAs.	Regular SLA review meetings to be held independently to the CQPRM's. In 2024/25 further alignment of the SLAs to the Integrated Performance Framework.	Sep-23		Overdue		Partially complete		We continue to include as an agenda item in the CQPRMs, once action 232402 has been completed we will look at holding separate meetings. Please note, the only exception is Wye Valley, we have service to service meetings set up from Nov to discuss performance etc. **09/09/2024** - SLA meetings to be further refined to reflect updated Integrated Quality and Performance Framework.					11	1495	Aug-24			
232405	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R5	Performance and quality monitoring against the SLA should clearly identify and consider: • The number of sessions expected and provided by each clinician. • Where the number of sessions provided is below the number expected, how the provider Health body proposes to rectify the deficit. • The cost per session expected and charged for each clinician. • Where the cost per session charged is higher than the cost expected, the reason for the increase and why the Health Board should be expected to pay it. NWSSP Audit and Assurance Services 14 • Clinical and operational issues which have occurred and what action the provider Health body proposes to take regarding them. Data should be readily and clearly available to support the review.	Internal review ongoing re the SLA activity delivered YTD compared to commissioned baseline and how this feeds into invoice validation. This aims to ensure robust oversight of SLA sessions delivered against expected activity (and any mitigating actions to address under performance), robustly costed and agreed financial schedules.	Dec-23		Overdue		Partially complete		This is linked to action 232402 and 232404					8	1495	Aug-24			
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home Governance	R2	Management should consider reviewing the circumstances for the submission of retrospective care packages in order to identify areas where improvements in communication could be made so that the Complex Care Teams are made aware of the patients sooner. This would reduce delay in submitting the packages for approval and also improve information for financial purposes.	It is recognised that the audit has highlighted the quality of compliance with our own administrative processes. The teams do struggle with capacity to meet the diverse demands generally, however, continuously strive to liaise with other teams for information. The aim is to consistently improve communication systems but there are limitations to what can be done within the current resources. Practice changes have taken place, and it is recognised that there is an interdependence between teams, although the impact falls on the performance of the Complex Care teams who cannot control the speed at which information is presented from external sources. With a small amount of additional resource to add to current practice changes, improvement in the speed of processes will occur. Both teams are mindful of patient need and out of panel decisions are made where this is necessary for timely implementation of patient care	31.10.24		Deadline Revised		Partially complete		There has been some progress and performance has seen a small improvement. Resources have been applied for through the IBG. Next step will be for Executive Committee to consider.							Aug-24	Jul-24		
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care	R3	Management should ensure that all care packages are undertaken within the required timescales. Where delays occur management should ascertain the reasons for the delay and take appropriate action to remedy the matter.	Capacity in the teams has been reviewed and will be addressed in a business case presented to the Investments and Benefits Group for consideration of some additional resources and a Committee report scheduled for August 2024.	31.10.24		Deadline Revised		Partially complete		**Aug 24** - The team has made some effociency improvements but without investmment this will not improve further. Executive Committee to consider the IBG paper.							Aug-24	Jul-24		
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home Governance	R5	Management should, review all information that is currently recorded on purchasing orders raised for continuing healthcare packages with a view to standardising the information to be detailed across the service	Work has commenced with finance colleagues around how improvements and consistency can be achieved.	31.10.24		Deadline Revised		Partially complete		**Aug 24** - Work is underway and there will be some task and Finish groups to look at options for streamlining processes.							Aug-24	Jul-24		
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care	R6	Management should ensure that key information regarding continuing healthcare activity and quality and safety issues are included in Health Board reports for submission to the appropriate Health Board Committees	There is a highlight report produced and shared monthly that illustrates CHC activity and more. This is being reviewed and revised with a meeting scheduled with the Performance team on 22.05.24 to see how they can support this work and create a more inclusive reporting system.	31.12.24		Deadline Revised		No progress		**Aug 24** - Although there has been work to progress this, the national position continues to be unsupportive of the health board data returns.							Aug-24	Jul-24		
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care/Deputy Director of Nursing	R7	Management should consider reviewing the reporting arrangements of the QSEG to allow for regular update reports from the group to be submitted to the Health Board's PEQS Committee	Reporting to PEQS has been discussed at QSEG and it is agreed that there does need to be the reporting of quality themes/issues in place. The current committee structure is changing to implement an integrated reporting system where quality and performance can be included in a single report.	31.10.24		Deadline Revised		Partially complete		**Aug 24** - Awaiting further discussion with new Exec Director regarding future reporting. In the meantime QSEG continues and the Complex Care Operational Management Group is in place with reporting to D & P Committee.							Aug-24	Jul-24		



PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementa							
232401	Structure Assessment 2023		Director of Corporate Governance/ Director of Nursing, Quality, Women and Family Health	2	R7	The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan to address this will be presented to the Patient Experience and Quality Committee in July 2024	Sep-24		Not yet due		Partially complete		April 2024 - plans in place and on target June 2024 - plans continue to progress with 12 teams/service areas now included within Datix. Work will continue over the summer to move more areas into the system. Full roll out may be slightly later than target but progress is positive. August 2024 - Heidi Sinclair attended the National Risk Steering Group last week, where Simeon Foreman, who is the PTHB board risk lead for the risk register stated that the aim is for the whole health board to be on the risk register by end of Feb 25. There was a lot of unrest amongst the other health boards as the Welsh Government deadline to be on the new system is April 25. PTHB don't have a problem with this.	National issues surrounding the once for Wales Datix system					1491	Apr-24	Mar-24		
242501	Review of Workforce Planning Arrangements		Director of People and Culture		R1	To ensure service level workforce plans are consistent, for the next planning cycle, the Health Board should ensure all directorates and/or service areas develop a workforce plan using the HEIW workforce plan template	Continue to roll out training that utilises the HEIW workforce plan template. • Provide periodical updates to Executive committee of those managers who are required to undertake the training; have done so, to ensure that the competencies to complete workforce plans are embedded within the organisation. Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.	Quarter 4 2024/2024		Not yet due		Partially complete										Jun-24		
242501	Review of Workforce Planning Arrangements		Director of People and Culture		R2	The Health Board should develop an evaluation framework to measure whether the roll out of workforce planning training is achieving its intended purpose and improving service level workforce planning	• Gain feedback from attendees both immediately after training and 3 months post training to understand effectiveness. • Measure the number of workforce plans produced across the organisation.	Quarter 4 2024/2025		Not yet due		No progress										Jun-24		
242501	Review of Workforce Planning Arrangements		Director of People and Culture		R3	Once the post that has been created to improve staff retention has been recruited to, the Health Board should develop a consolidated programme of retention activities with a clear evaluation framework focusing on what impact its activities are having on improving staff retention	The retention lead will pull all of our retention activities together and undertake a self-assessment and subsequent gap analysis against the national retention plan, identifying where improvements can be made. • Staff retention rates will be measured and reported through the Health Board's Workforce Performance Framework and will Q4 2024-25 Deputy Director WOD Page 31 of 34 - Review of Workforce Planning Arrangements – Powys Teaching Health Board include analysis from staff exit questionnaires.	Quarter 4 2024/2025		Not yet due		No progress										Jun-24		
242501	Review of Workforce Planning Arrangements		Director of People and Culture		R4	To ensure the Workforce and Culture Committee has good oversight of the overall progress and impact of delivering the Workforce Futures programme, the Health Board should develop the update reports on each of the Workforce Futures strategic priorities to clearly highlight progress against key actions and milestones as agreed in the Integrated Plan. The report should also include key metrics to illustrate progress, and the impact of delivery	• Provide Workforce and Culture Committee with 'in-year' updates which will identify and include progress against key metrics. These will demonstrate the impact and illustrate progress that the actions are having against each of the key workforce strategic priorities aligned to the workforce futures strategic framework and included in the integrated plan.	Quarter 1-4 2024/2025		Not yet due		No progress										Jun-24		
242501	Review of Workforce Planning Arrangements		Director of People and Culture		R5	The Health Board should identify organisations across the UK with similar workforce challenges to benchmark its workforce performance and share good practice	• Work with the Health Boards Corporate Performance Team to try to identify similar organisations whose workforce metrics can be accessed in order to benchmark	Quarter 4 2024/2025		Not yet due		No progress										Jun-24		

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementa							
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health	Director of Primary Care, Community and Mental Health	R1	The Health Board should review the relative maturity of clusters, to reflect on the existing arrangements, address any potential gaps and strengthen Health Board support where necessary.	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects at cluster level through 'start well', 'live well', 'age well' programmes – a bottom-up approach to increase cluster maturity. Progress will be monitored via the ACD readiness checklist and assurance provided through the RPB Executive Grou	Mar-25		Not yet due		No progress										Jul-24		
242502	Primary Care Follow-up Review		Director of Finance, Capital and Support Services	Director of Finance, Capital and Support Services	R2	The Health Board should: 2.1. calculate a baseline position for its current investment and resource use in primary and community care. 2.2. review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	Establish a summary of the baseline position to monitor current investment and resource used in primary and community care. Establish a mechanism to report changes in expenditure compared to the baseline to identify any shift in resources.	Jun-24		Not yet due		No progress										Jul-24		
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health & Director of People and Culture		R3	The Health Board should examine how it can gather additional workforce data on the number and skills of all staff working within its primary care settings, in the absence of national solutions.	To capture and review workforce data across Independent Contractors and the impact of instability in primary care due to increase in demand and recruitment challenges, to include: • Identifying workforce needs in primary care • Improving workforce planning and supporting sustainability •Promoting and encouraging multi�professional working • Improving access and capacity for student training and placement opportunities to promote longer term sustainability of Powys primary care. This will inform the roll-out of the Primary Care Workforce Plan across Powys (linked to National Workforce Plan)	Mar-25		Not yet due		No progress										Jul-24		
242502	Primary Care Follow-up Review		Corporate Secretary		R4	The Health Board should develop an action plan for raising the profile of primary care in the organisation and ensuring sufficient coverage of primary care challenges and performance within committee agendas	Develop a timeline for presentation of primary care reports at Executive Committee and Board level to provide regular reporting and assurance, to include challenges and risks.	Jun-25		Not yet due		No progress										Jul-24		
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissioning		R5	The Health Board should improve oversight at Board and committee level of performance within primary care by: 5.1. increasing the coverage of primary care performance within its Integrated Performance Report. 5.2. increasing the focus on outcomes and experience	Progress the development of a Primary Care Dashboard as part of Integrated Performance Report presented to Executive and Board Committees. Frequency to be agreed	Dec-24		Not yet due		No progress										Jul-24		
242502	Primary Care Follow-up Review		Assistant Director of Primary Care		R6	The Health Board should strengthen its Primary Care Services Team by: 6.1. Reviewing the resources available to ensure it has the necessary capacity to deliver local and national priorities, alongside meeting day-to-day operational and business need. 6.2. Ensure that training and development opportunities extend to all members of the team and develop a succession plan.	in conjunction with ongoing operational requirements, including contract reform. Review resources available to increase capacity in the Primary Care Services Team. Develop a training plan for the Primary Care Services team to support succession planning and ongoing resilience.	Jun-24		Not yet due		No progress									Aug-24	Jul-24		

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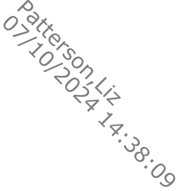
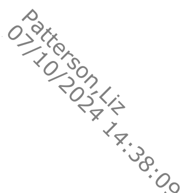
PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementa							
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health		R7	The Health Board should establish a central primary care services management group to manage primary care services as a whole and maximise opportunities for integrated working.	Establish a Primary Care Services Management group covering the four contractor professions to include clinical, managerial and finance representation	Sep-24		Not yet due		No progress									Aug-24	Jul-24		



PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementa							
232401	Structure Assessment 2023		Director of Nursing, Quality, Women and Family Health		R5	Develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from patients, service users and staff	May-24		Overdue		No progress										Mar-24		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Agenda item:3.7

Audit Risk and Assurance Committee	08 October 2024
Subject:	Interim Report for Losses and Special Payments for the period 1st April 2024 to 31st August 2024
Approved and presented by:	Executive Director of Finance, Capital Estates and Support Services / Deputy Chief Executive
Prepared by:	Assistant Director of Finance (Accounting and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To provide the Interim Report of Losses and Special Payments for the period 1st April 2024 to 31st August 2024.

RECOMMENDATION(S):

The Audit Committee is asked to:

- **RECEIVE** this Interim Report on Losses and Special payments covering the period 1st April 2024 to 31st August 2024.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

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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:
This paper provides an interim report for the period 1st April 2024 to 31st August 2024. The following figures relate to payments made on behalf of cases for which Powys THB have responsibility. The THB only accounts for the claims relating to the Residual Clinical Negligence (relating to former Health Authorities) cases. These cases are scrutinised and paid by the Welsh Risk Pool advisory panel and therefore are not required to be included below as the THB does not make the payments. 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.

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- 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. A summary position on overall open cases is also provided to the Patient Experience, Quality and Safety 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 2024 to 31 August 2024, the THB made payments in respect of 4 cases totalling £16,706.92 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 not received 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)	5	4	£16,706.20
Total	**5**	**4**	**£16,706.20**

Powys Teaching Health Board continues to hold a small claims portfolio; there are currently 17 cases which are which are inclusive of clinical negligence (12),and personal injury (5) claims with NWSSP Legal and Risk Services instructed to act on behalf of the health board.

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 2024 to 31st August 2024 are included in Appendix Aii.

	No. of payments/receipts	No. of cases	£
Redress Payments	6	4	£ 9,115.98
Total	**6**	**4**	**£9,115.98**

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Redress Receipts	0	0	£0
Total	**0**	**0**	**£0**

There are currently 3 open redress cases at variable stages

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 2024 to 31st August 2024 are included in **Appendix Aiii.**

	No. of payments/receipts	No. of cases	£
GMPI Payments	4	2	£5,769
Total	**4**	**2**	**£5,769**
GMPI Receipts	0	0	£0
Total	**0**	**0**	**£0**

There are currently 8 open GMPI cases at variable stages of review/progression.

There has been no reimbursement to date from Welsh Risk Pool during 2024/25.

Other Special Payments

Details of the payments are included in Appendix Aiv.

	No. of payments/receipts	No. of cases	£
Other Special Payments	2	2	£447.95
Total	**2**	**2**	**£447.95**

Conclusion

The Audit Committee is asked to note the above interim report for 2024/25 for losses and special payments. These have been approved in line with the Scheme of Delegation on losses and special payments within the THB.

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Full details including supporting listing is attached at Appendix Ai – Aiv

NEXT STEPS:

The Audit Committee will receive an update every 6 months on losses and special payments.

Appendix Ai

Losses And Special Payments for 2024-25 Financial Year (Interim) 1st April 2024 to 31st August 2024					Appendix Ai
Claim Type	Payment Type	Welsh Risk Pool Reference	Date of Pay	Payments	Amount by case
Clinical Negligence	Defence Costs	MN/030/1850/LDA	May-24	£30.00	£30.00
Clinical Negligence	Defence Costs	MN/030/1388/DK	Jun-24	£2,880.00	
Clinical Negligence	Defence Costs	MN/030/1388/DK	Jun-24	£2,035.00	£4,915.00
Clinical Negligence	Claimant Costs	MN/030/1441/EC	Aug-24	£5,549.27	£5,549.27
Personal Injury	Damages	PI/030/1780/RHJ	Jun-24	£6,212.65	£6,212.65
		TOTAL		£16,706.92	£16,706.92
Reimbursements from Welsh Risk Pool					
Receipt Date	WRP Reference	Laspar Reference		Amount	
Nil receipts to date					
		Total		£0.00	

Appendix Aii

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Redress Losses And Special Payments for 2024-25 Financial Year (Interim)					
1st April 2024 to 31st August 2024				Appendix Aii	
Payment Date	Redress Reference	WRP Reference	Nature of Payment	Amount	Amount by case
Apr-24	COM1048	RED7A7-0043/CD	Damages	£5,000.00	
May-24	COM1048	RED7A7-0043/CD	CRU	£913.00	
May-24	COM1048	RED7A7-0043/CD	Claimant Costs	£1,920.00	£7,833.00
Jun-24	RED67/INC7543	PTR/030/1851/JC	Defence Costs	£35.90	£35.90
Jul-24	INC9358	PTR/030/1883/RR	Defence Costs	£764.31	£764.31
Aug-24	RED69	PTR/030/1898/DS	Defence Costs	£482.77	£482.77
			Total	£9,115.98	£9,115.98
Reimbursements from Welsh Risk Pool					
Receipt Date	WRP Reference	Redress Reference		Amount	Amount by case
Nil receipts to date					
			Total	£0.00	£0.00

Appendix Aiii

GP Indemnity Losses And Special Payments for 2024-25 Financial Year (Interim)				
1st April 2024 to 31st August 2024			Appendix Aiii	
Payment Date	Welsh Risk Pool Reference	Nature of Payment	Amount	Amount by case
Apr-24	GPM/030/1650/CAP	Defence Costs	£1,050.00	
Jul-24	GPM/030/1650/CAP	Defence Costs	£2,364.00	
Jul-24	GPM/030/1650/CAP	Defence Costs	£1,155.00	£4,569.00
Aug-24	GPM/030/1895/LKT	Defence Costs	£1,200.00	£1,200.00
		Total	£5,769.00	£5,769.00
Reimbursements from Welsh Risk Pool				
Receipt Date	Welsh Risk Pool Reference	Nature of Reimbursement From Welsh Risk Pool	Amount	
Nil receipts to date				
		Total	£0.00	

Appendix Aiv

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Other Losses And Special Payments for 2024-25 Financial Year (Interim)

1st April 2024 to 31st August 2024

Appendix Aiv

Payment Date	Losses Reference	Nature of Reimbursement	Amount
Aug-24	256C4EG0001	Replacement personal hygiene item broken by staff member	£19.95
Aug-24	256C4EG0002	Staff member glasses broken by Patient	£428.00
		Total	**£447.95**

Patterson,Liz
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Agenda item: 3.8

Audit, Risk and Assurance Committee	08 October 2024
Subject:	**SINGLE TENDER WAIVERS**
Approved and presented by:	Executive Director of Finance, Capital Estates and Support Services / Deputy Chief Executive
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To inform the Audit Risk and Assurance Committee that there has been no Single Tender Waiver requests made between 1 July 2024 and 30 September 2024.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there has been no Single Tender Waiver requests made between 1 July 2024 and 30 September 2024.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	N
2. Provide Early Help and Support	N
3. Tackle the Big Four	N
4. Enable Joined up Care	Y
5. Develop Workforce Futures	Y
6. Promote Innovative Environments	N
7. Put Digital First	N
8. Transforming in Partnership	N

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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.

HEADING:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its July 2024 meeting which covered the period from 1 May 2024 and 30 June 2024 was a nil usage.

No Single Tender Waiver Requests have been received between the period 1 July 2024 and 30 September 2024.

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.

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IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe					
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

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Agenda item: 3.9

Audit Risk and Assurance Committee	8 October 2024
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 2024/25.

RECOMMENDATION(S):

It is recommended that the Audit Risk & Assurance Committee:

- **RECEIVE** the update report for discussion.
- **TAKE ASSURANCE** that appropriate counter fraud systems are in place.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	N
2. Provide Early Help and Support	N
3. Tackle the Big Four	N
4. Enable Joined up Care	N
5. Develop Workforce Futures	N
6. Promote Innovative Environments	N
7. Put Digital First	N
8. Transforming in Partnership	Y

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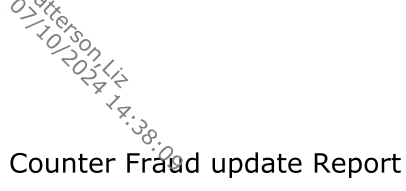
IMPACT ASSESSMENT – NOT REQUIRED



Item 3.12

Counter Fraud Update Report

8th October 2024

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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.

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	**40**	**21**
Inform and Involve	**55**	**32**
Prevent and Deter	**113**	**37**
Hold to Account	**100**	**50**
TOTAL	**308**	**140**

4. STRATEGIC GOVERNANCE

An All Wales Counter Fraud Workshop was hosted by NHS Finance Academy. Guest speakers from DWP Benefits Fraud and NHS Counter Fraud Authority attended to provide detail around their approach to counter fraud activity. Counter Fraud Specialists then discussed Counter Fraud approach in NHS Wales and potential future structure. A further workshop is being planned to discuss approach with a wider range of attendees to include Directors of Finance, Audit Committee Chairs, Welsh Government and Counter Fraud representatives.

5. INFORM AND INVOLVE

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A revised reporting system for Counter Fraud Services is being explored. This will seek to update the existing manual process to utilise available applications to automate reporting process as well as make it easier to interrogate context behind

figures. A meeting has been held with Internal Audit colleagues who have developed a database and reporting suite, learning has been gained and ongoing support offered. A further meeting with CFS Wales has been undertaken and an action plan agreed to take forward feasibility.

The Lead LCFS and Support Counter Fraud Officer have conducted fraud awareness visits to Health Board sites. This has enabled refresh of counter fraud materials at sites such as fraud awareness posters and reading materials as well as face to face engagement with staff aimed at developing good links across Health Board sites.

12 Blog posts have been released via the intranet pages since the start of the year. This means of communication remains popular with staff and will continue to deliver an approachable means of communication relating to fraud awareness. The counter fraud blog continues to receive good coverage and traction.

6. PREVENT AND DETER

The Counter Fraud Team have confirmed data submission requirements for the next iteration of the National Fraud Initiative exercise. Cabinet Office timetable indicates that matched data reports will be available for review from 20th December 2024. Review of matches will commence upon receipt and a progress report will be brought to the attention of this Committee in Summer 2025.

The Counter Fraud Team have completed work in relation to the national NHS Counter Fraud Authority led proactive exercise around procurement. The exercise has centred on Due Diligence and Contract Management elements of the procurement cycle. A questionnaire identifying controls relating to known fraud indicators for each area has been completed and a sample of 8 contracts has been reviewed to test compliance. A report is anticipated to be issued by NHS Counter Fraud Authority before year end.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is summarised in Appendix to this 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.

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8. RECOMMENDATION

The Committee is asked to:

- **RECEIVE** the update report for discussion.
- **TAKE ASSURANCE** that appropriate counter fraud systems are in place.

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Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/23/01970	13/09/2023	Overpayment of Salary	Staff	Staff member terminated by Health Board continued to be paid for 8 months	Subject was dismissed due to working without correct immigration status. Subject has been traced via Home Office who confirmed issuance of a new visa and is believed to be in UK. Investigation to be undertaken by NHS CFS financial investigator who traced subject and interview has taken place. Follow up enquiries are being undertaken. Separately the subject has agreed repayment in full which has been arranged via Payroll.
INV/23/02632	22/11/2023	Fraudulently Amended Medical Records	Staff	The medical records of a patient have been amended with allegations that files have been deleted, and/or fabricated in order to imply that they have mental health issues	Information received via Fraud and Corruption Reporting Line. Enquiries have been undertaken with the NHS CFA Central Intelligence Unit, who received the report, to ascertain any further details such as those of reporting person. None were available. Investigation is to seek patient records for the individual to conduct review. This is difficult without direct consent due to duty of confidentiality rules. An approach has been made to medical records to confirm whether a patient in name of potential victim has in fact been treated at the Health Board. Information Governance colleagues have been engaged following trace of an individual patient. System audits are being undertaken relating to this patient's records. WCCIS and WPAS systems have been audited as part of this case under Information Governance

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Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					NIIAS processes. No unusual activity was established and no records have been found to have been deleted. There are no remaining lines of enquiry in this investigation and the original allegation was not unsubstantiated in findings.
INV/23/02673	24/11/2023	Working Elsewhere Whilst Sick	Staff	Staff member absent due to sickness were seen to be working during sick period	Investigation has commenced with approach to a witness. Further witnesses were identified following this discussion who were approached. A witness statement was gathered corroborating allegation details. An interview under caution has been conducted and follow up enquiries are being undertaken. Enquiries undertaken have led to evidence that corroborates original allegation as well as potential further offences relating to a further employer. A case file is being prepared for CPS review for suitability for prosecution.
INV/23/02770	06/12/2023	Overbilling	Contractor	Contractor via All Wales contract has overinflated claims for services provided	Allegations centre on 'double booking' charges for services provided and charges for services not provided. A meeting was held with contract manager who disclosed that this contractor had separately identified significant value of charges that needed to be returned to the NHS across Wales. The contract manager is to meet the contractor to discuss particular concerns raised and ascertain any service issues linked to charges being claimed and subsequently returned. Additionally, contractor has

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Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					expressed difficulties to contract manager around access to sites at times. Non-access to site would be chargeable under contract. Given potential All Wales nature of this concern information was discussed with CFS Wales. LCFS and CFS Wales in agreement that issue appears to be contract management issue at this stage and should initially be addressed under those processes. A refreshed approach to this contract has been agreed between the Contractor and Contract Manager. A risk assessment will be undertaken in relation to these revised processes. The All Wales contract relating to this matter has been reviewed as part of a national procurement exercise and findings will feed into the risk assessment.
INV/23/02907	03/01/2024	Working Elsewhere Whilst Sick	Staff	Staff member absent due to sickness has been working during sickness period	Initial enquiries have confirmed sickness period. Investigation detail has been shared with subject's managers for consideration. A Data Protection Act request is being considered but would likely lead to 'tip off' to the subject. Alternative means of confirming secondary working is being explored. Information requests have been issued to other NHS health bodies following identification of potential secondary employment. A case conference was undertaken in relation to this investigation and open source research reviewed. It was established that a corporate entity was actual the owner of the business in question

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Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					and a request for information has been made to them under the Data Protection Act.
INV/24/00525	04/03/2024	Working Elsewhere Whilst Sick	Staff	Staff member currently employer via a fixed term contract has been alleged to have been working Bank shifts for other NHS organisations.	Enquiries have established the sick leave records of the subject and discussions with subject's manager have been undertaken. Evidence established that subject was witnessed working at a community health care site during a period of sick leave. Rostering information has been requested to enable review. A witness has been established who has been interviewed and agreed to provide a statement. A request for information has been mad to a potential secondary employer identified by the witness has been issued.
INV/24/01639	27/06/2024	Forgery	Ex-Employee	A former employee has submitted two payslips claiming that they have not received payments for bank shifts totalling £597.26.	Upon initial review it appears that the paper payslips have been torn and stuck together before submission to give impression that a £0 amount payslip had been generated. The original electronic payslips were verified Payroll have confirmed that the payments in question have already been paid to the subject. Draft witness statements have been issued and interview with subject will be undertaken once confirmed.
INV/24/01893	25/07/2024	Dispensing of Medication Concerns	Staff	A nurse has been alleged to be dispensing more medication than required, stating that they will give a patient more medication so they don't have to see the GP, and	The Health Board's Chief Pharmacist was contacted and concerns disclosed. Initial enquires have established that the subject is not a prescriber. The only medicines that should be issued by this subject are stock items for supply on discharge. Ordering

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Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
				that the nurse can then claim it back.	patterns are being examined to establish any outlier data. No concerns are logged against the subject and management have no local concerns regarding their work. Currently awaiting outcome of Pharmacy order review.

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Closed Cases

Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/23/01425	20/07/2023	Dental	Contractor	Dental contractor alleged to be inflating treatment banding	Information has been disclosed to Primacy Care and Medical Director. An analysis of treatments is being undertaken by NHS BSA Dental Advisor to inform investigation. This analysis was due to be completed by end of January 2024 however an extension was granted to allow further time for paperwork to be collected by the contractor. A report has subsequently been issued by the BSA dental advisor. This was reviewed by CFS Wales and the counter fraud dental advisor. All parties are in agreement that whilst there are clear issues in the claims identified these fall short of criminal fraud. Parallel professional concerns processes are continuing and this matter is to be addressed under that procedure.
INV/24/01626	26/06/2024	Working Elsewhere Whilst Sick	Staff	Concerns raised by subject's manager relating to subject's level of sickness absence and recently discovered undeclared secondary working.	Enquiries have established subject's leave record and a line of enquiry with another NHS body to establish secondary employer. Investigation then compared shifts between secondary employer and sickness record. No cross over indicating secondary work whilst sick was established.

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Agenda item: 3.10

Audit Risk and Assurance Committee	8 October 2024
Subject:	**Information Governance Key Performance Monitoring Report**
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Head of Information Governance, Records and Data Protection Officer
Other Committees and meetings considered at:	Executive Committee - 02 October 2024

PURPOSE:

To provide assurance of the arrangements in place to ensure the health board complies with its statutory obligations in relation to data protection legislation, national frameworks, and good practice.

RECOMMENDATION(S):

The Committee are asked to:

- Note the contents of the report for assurance.
- Support any actions required to improve compliance.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	The work undertaken of the Information Governance Team is fundamental in providing assurance to the population of Powys that their data and information is safe and secure. Streamlined processes are put in place to support staff. Close collaboration with NHS Wales and key stakeholders ensuring a joined up streamlined approach in ensuring the health board is compliant with its obligations under data protection legislation.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:

This reporting period covers Quarter 1 2024/25, 1st April 2024 to 30 June 2024 with a breakdown of performance and supporting statistics provided in the detailed background and assessment section of the paper. A high-level overview of performance is listed below:

Freedom of Information Requests:

- 128 requests received with 24 breaches. The longest breach was 51 days (reason due to service delays), where the legislative timeframe is 20 working days.
- FOI compliance is at 81% and continues to remain below the Information Commissioner's target of 90%.
- Figures for this quarter remain consistent with the last quarter, but there has been an 19% increase compared with 2023/24 Q1 figures.
- 3 requests for Internal Reviews, following response no further action taken by the requestors.

Environment Information Regulations: One EIR request was received and processed within the 20 working days.

Requests for personal information:

- 199 requests for personal information (living or deceased)
- 4 breaches under UK GDPR timeframe, where legal timeframe is 28 calendar days, longest breach was 64 days.
- Compliance this quarter has increased to 98% and remains above the locally agreed target of 90%. The number of requests has decreased slightly from 209 (last quarter) to 199, however the Committee is asked to note that compared with Q1 in 2023/24 there has been a 26% increase of requests.

IG Training:

NHS Wales IG Mandatory E-Learning: The overall compliance rate for the health board is 90% which is an increase of 1% from Q4 2023-24 and remains above the national target of 85%, however 15% of new starters failed to complete their training within the national 6-week target. Work continues to analyse reasons for this and improve compliance.

Internal Training - The IG Team delivered 5 bespoke training sessions to services.

Datix Incidents (Breach Reporting): There were 31 Information Governance related incidents reported, 11 incidents were not reported within the UK GDPR regulatory 72 hours, mainly due to service delays in reporting. None of the

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recorded incidents were deemed reportable to the Information Commissioner's Office (ICO).

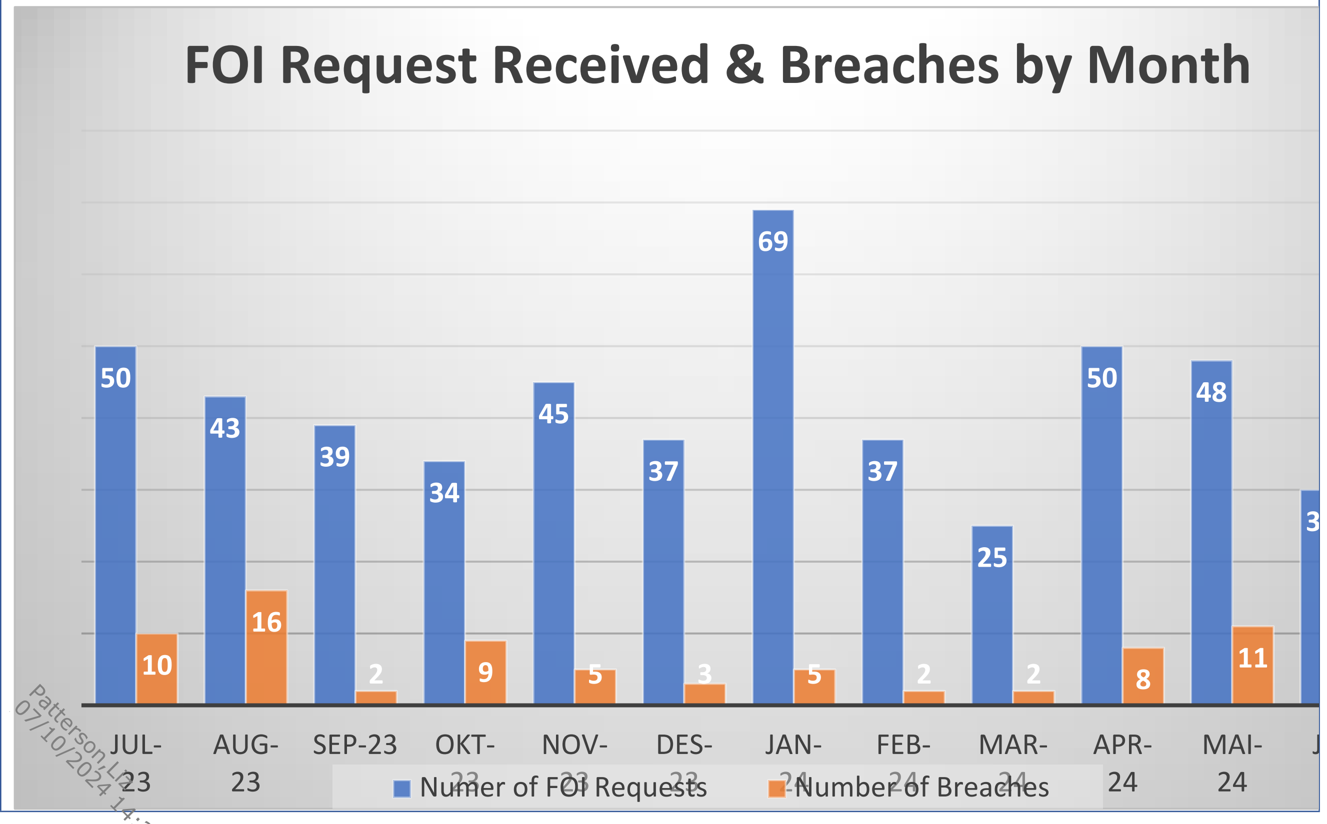
Compared with the previous quarter, there has been a drop in the number of incidents reported and compliance against the 72-hour reporting rule showing a marginal improvement.

The IG team continues to support services with actions and different ways of working to mitigation further incidents. Themes from these incidents also influence future IG training sessions along with Policy and Guidance development.

Audit and Monitoring:
The National Intelligent Integrated Audit Solution (NIIAS): A national update to move the platform to google cloud services, resulted in technical issues preventing NHS organisations running reports for the months April to end of July. This was fixed in August and the backlog of reports have been run successfully. During this time 11 notifications had not been picked up (4 members of staff accessing their own record and 7 members of staff potentially accessing a family member records). These have all been investigated, none of the 11 incidents required reporting to the ICO.

BACKGROUND

Freedom of Information Requests: The graph below shows 12 months' worth of figures as comparison (July 2023 – June 2024):



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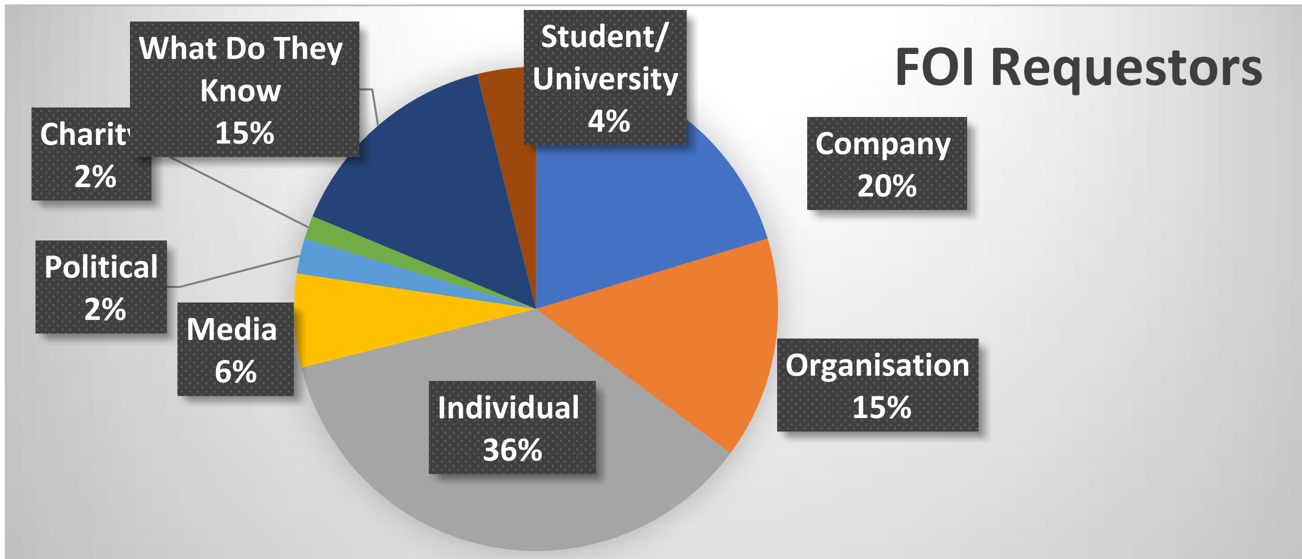
The top four FOIA Exemptions used:

- Section 12 - Costs of complying with request will exceed the cost limit.
- Section 40(2) - Data Protection and Personal Information.
- S43 - Trade secrets and Prejudice to Commercial Interests.
- S21 - Information is reasonably accessible by other means.

The main causes for the 24 breaches were:

- Service delays in providing responses within the timeframe.
- Increased number of complex requests.
- Quality Assurance Approval

The chart below illustrates categories of FOI Requestors during this reporting period:



Requests for personal information (living and deceased): The graph below shows 12 months' worth of figures as comparison (July 2023 – June 2024)

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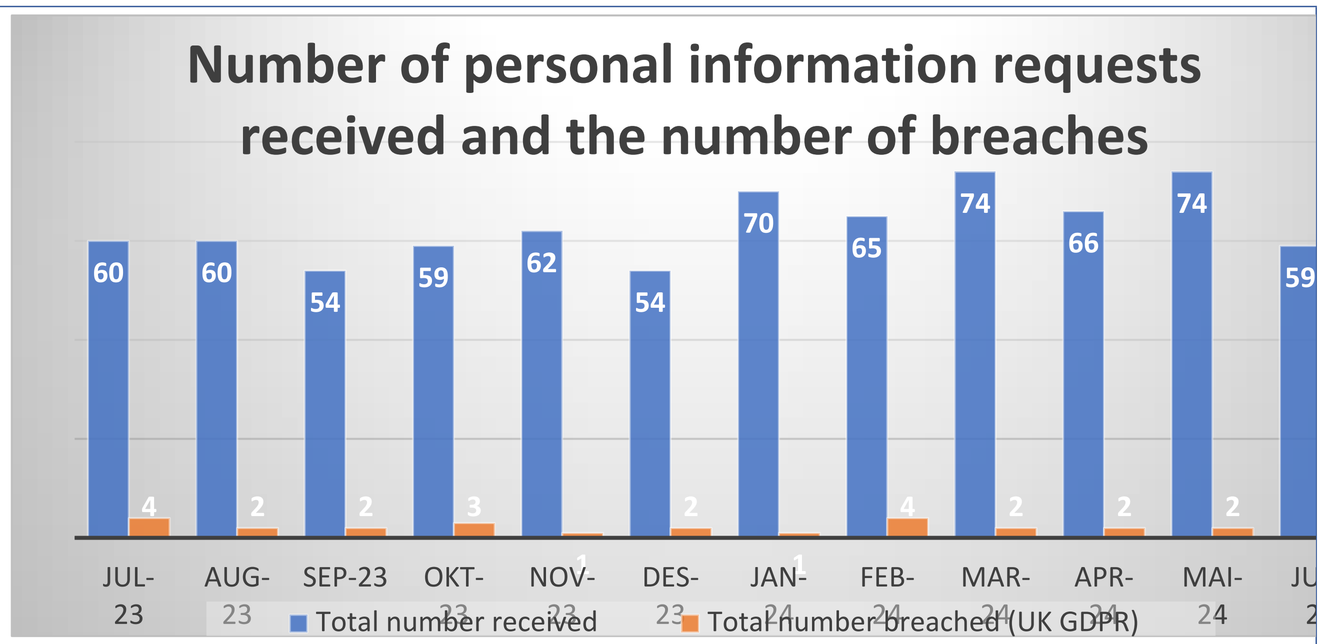

The main cause for the 4 breaches were:

- Staffing issues within service areas resulting in the records not supplied in the period required.

Medical Examiner Service - One disclosure exceeded the 72-hour expected timeframe set by the Medical Examiner Service, by 3 days. This late disclosure was caused by a delay in receiving notes from the ward.

Datix Incidents: The top three themes identified during this reporting period were:

- IG - Unintended recipient external (letter, email) – 8 incidents
- IT/System Security or Function - Photocopier / printer issue – 5 incidents
- IG – Breach of sensitive data - 3 incidents

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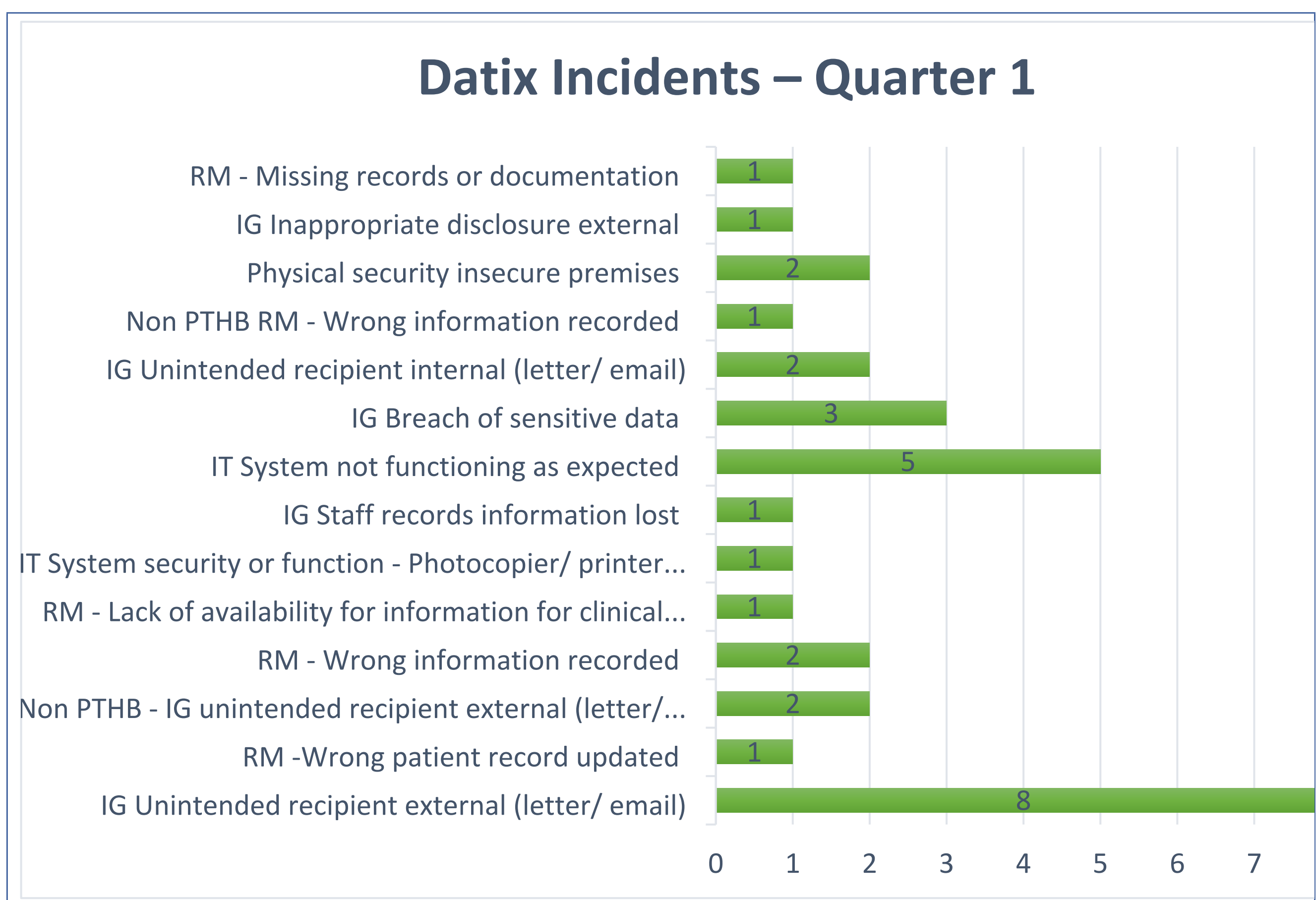

Information Governance Training:

Internal Training - Five bespoke sessions have been delivered by the IG team during this reporting period:

- Information Governance awareness training was provided for the North Therapy Team and Volunteering Services x 2
- SAR training sessions also completed. X 3

NHS Wales IG Mandatory E-Learning - To improve compliance with New Starters, the IG Team are issuing reminders to those who do not complete the module within the 6-week period.

The table below shows a breakdown of IG Training compliance for new starters during Q1 2024/25:

Mandatory IG Module Completion	Headcount	Complianc
Prior To Joining	17	
Not Completed	**14**	
Completed within 6 Weeks	52	
Completed after 6 Weeks	8	
Grand Total	91	85% Training Comp

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The table below shows a detailed breakdown of mandatory IG training compliance for each directorates :

Directorate	Assignment Count	Required	Achieved	Compli %
Chief Executive Office	19	19	16	84
Community Care & Therapies	1058	1058	987	93
Community Dental Service	73	73	63	86
Corporate Governance	18	18	17	94
Estates & Works	50	50	46	92
Finance Directorate	103	103	96	93
Facilities & Support Services	208	208	155	74
HCRW	78	78	69	88
Medical Directorate	16	16	13	81
Mental Health	483	483	421	87
Medicines Management	37	37	36	97
Nursing Directorate	33	33	29	87
Public Health Directorate	74	74	72	97
Planning Directorate	24	24	24	100
People & Culture Directorate	79	79	74	93
Primary Care	23	23	21	91
Therapies & Health Sciences	19	19	19	100
Women and Children	212	212	192	90
Grand Total	2607	2607	2350	**90.**

In line with the workplan, the team are due to undertake a reminder email exercise to all non-compliant staff during quarter 3.

NEXT STEPS:

- Explore ways of further improving IG knowledge around the organisation through group awareness sessions, training and digital methods.
- Continue to work closely with services to identify and reduce the delays and breaches with the processing of requests for information.

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- Undertake an in-depth analysis of mandatory training levels for new starters and directorates who are currently below 85% and look for opportunities to increase compliance.

Continued assurance reports will be submitted to the Committee quarterly.

IMPACT ASSESSMENT – NOT REQUIRED

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Agenda item: 3.11

Audit, Risk and Assurance Committee	**Date of Meeting: 8 October 2024**
Subject:	**POWYS TEACHING HEALTH BOARD (PTHB) BOARD MEMBERS DECLARATION OF INTERESTS, GIFTS and HOSPITALITY 2024/2025**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee -18 September 2024

PURPOSE:

This paper presents the position on 5 September 2024 in respect of Register of Interest and Gifts and Hospitality for Independent Members and Executive Directors and updates on developments being made to the processes.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **RECEIVE** the contents of Register of Interests, Gifts and Hospitality for PTHB Board Members at 5 September 2024; and
- take **ASSURANCE** that the organisation has appropriate processes to support the collection, management and reporting of Declarations of interest, Gifts and Hospitality in line with the Standards of Behaviour Policy.

The report will be provided to the Board on the 27 November 2024.

Approve/Take Assurance	Discuss	Note
Y	N	**Y**

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:
The Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour. The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership. In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions.
BACKGROUND
In accordance with the requirements of PTHB's Standing Orders and Standards of Behaviour Policy, a report is required to be received by the Audit, Risk and Assurance Committee (ARAC) which details the Declarations of Interest, Gifts and Hospitality received by Board Members. The Register of Interests is maintained by the Corporate Governance Department with each declaration reviewed and checked by the Director of Corporate Governance with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests, gifts and hospitality. The register for Declaration of Interests 2024/25 at 5 September 2024 is attached at **Appendix A** and Register of Gifts and Hospitality received to date at **Appendix B.** All employees and Independent Members of the Board must ensure that they are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the Health Board. Declarations must be made to the Health Board for recording in the Register of Interests any relevant interests at the commencement of employment, whenever a new interest arises or if asked to do so at periodic intervals by the Organisation. The onus regarding declaration will reside with the individual employee or Independent Member. An escalation process has been implemented by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted. Progress has been made in this area and the Corporate Governance Team is now pursuing best practice and encouraging all staff to declare interests where applicable. To actively promote the Standards of Behaviour Policy and Declarations of Interests across the organisation, the Corporate Governance Team is reviewing current processes of how declarations are made and recorded. In addition, work

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is underway to develop a communications plan, and to streamline the process of which declarations are made and recorded.

The Standards of Behaviour Framework summary is set out in **Appendix C** (available on request). The Director of Corporate Governance has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on PTHB's website to ensure openness and transparency.

NEXT STEPS:

The Register of Declaration of Interests, Gifts and Hospitality for (Board Members) for 2024/2025 will be published on the PTHB website and will be maintained up to date by the Corporate Governance team.

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POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25								Updated: SPTEMBER 2024	
Position	**Name**	**Nature of Interest**	**Nature of Declaration**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**	**Last day in Powys Teaching Health Board**
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/06/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Apr-18	Ongoing	Employee, Swansea University. (Manager of Community, Equalities & Chaplaincy, Student Services)	Salaried Employment		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		

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Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University- Various Healthcare Programmes	Salaried Employment	08/07/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal						05/09/2024	
		Spouse/Partner/Other							
		Personal							
		Spouse/Partner/Other	NIL	NIL	NIL				
		Personal	NIL	NIL	NIL	NIL	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL	22/05/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant		
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		

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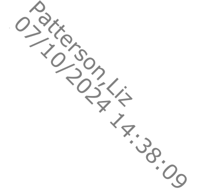
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	NIL	NIL	NIL	NIL	NIL	22/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor - Newydd Housing Group Limited (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Current	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Oct-22	Current (to Sept 2024)	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		



Powys Teaching Health Board Register of Gifts and Hospitality 2024/2025.

Date of Gift	Donor/Contact Name	Item Donated	Organisation	Channel received	Notes	Value likely to exceed £25	Accepted/Declined
03.05.2024	Databricks	Mini Jenga Game Mug Scented Candle Hot Chocolate Powder	Databricks 22 Berners St London W1T 3LR	Post	Posted to Bronllys Hospital, PTHB	No	Accepted by Data Services

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Appendix C - Standards of Behaviour Framework Summary

The Board has described its vision that underpin the way that services are provided and to support this, all employees must ensure that they carry out their roles with dedication and commitment to the Special Health Authority and its core values.

All staff must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for

To uphold these principles, you must:

- Ensure that the interests of patients and the public remain paramount;
- Be impartial and honest in the conduct of your official business;
- Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abuse your official position for personal gain or to benefit your family or friends;
- Not seek advantage or to further private business or other interests in the course of your official duties, and;
- Not seek or knowingly accept, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the SHA.

The Standards of Behaviour Framework Policy outlines the arrangements within the Special Health Authority to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship (even if these are declined). Further guidance is available via the Standards of Behaviour Policy on the intranet site.

It is your responsibility to ensure that you are familiar with the requirements of the Policy and supporting guidance. The relevance

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<table>
<tr>
<td>their decisions and restrict information only when the wider public interest clearly demands it;

▪ Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;

▪ Leadership – Individuals should promote and support these principles by leadership and example.</td>
<td>of this information will vary depending on your role within the Special Health Authority and your interests outside of your employment.

Remember that the need to declare an interest also includes those of your close family and possibly friends.

Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions.

Obtain your Directors permission before accepting any commercial sponsorship or hospitality;</td>
</tr>
<tr>
<td>In summary:-
DO:</td>
<td>In summary:-
DO NOT:</td>
</tr>
<tr>
<td>• Make sure that you are not in a position where your private interests and NHS duties may conflict.

Declare any relevant interests. These include:-

• Directorships, including Non-Executive Directorships held in private companies or PLCs.;
• Ownership or part-ownership, of private companies, businesses, or consultancies likely or possibly seeking to do business with the Special Health Authority.
• A position of authority in a charity or voluntary body in the field of health and social care;
• A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team;
• Sponsorship or funding from a known NHS supplier or associated company/subsidiary;</td>
<td>• Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;
• Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined;
• Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
• Abuse your position to obtain preferential rates for private deals;
• Unfairly advantage one competitor over another or show favouritism in your dealings with commercial organisations;
• Use NHS resources for your own private use.

If you need any further guidance, please contact the Corporate Governance Team via email or Microsoft teams. powysdirectorateofCorporatGovernance@wales.nhs.uk</td>
</tr>
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• Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice; • Anything else that could cause a potential for conflict.	

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Agenda item: 3.12

AUDIT RISK & ASSURANCE COMMITTEE	08 October 2024
Subject:	**IMPLEMENTATION OF WELSH HEALTH CIRCULARS**
Approved and presented by:	Director of Corporate Governance
Prepared by:	Corporate and Governance Assurance and Risk Officer
Other Committees and meetings considered at:	Executive Committee 18 September 2024
Appendices:	**Appendix 1-** Current outstanding WHCs and Ministerial Directions **Appendix 2 -** Current completed WHCs and Ministerial Directions since last report

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **RECEIVE** the report and
- **Take ASSURANCE** the organisation has a system in place to receive, monitor and implement Welsh Health Circulars and Ministerial Directions.

Approve/Take Assurance	Discuss	Note
Y	**Y**	**Y**

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	Y
2. Provide Early Help and Support	Y
3. Tackle the Big Four	Y
4. Enable Joined up Care	Y
5. Develop Workforce Futures	Y
6. Promote Innovative Environments	Y
7. Put Digital First	Y
8. Transforming in Partnership	Y

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EXECUTIVE SUMMARY:

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

An overview of the position as of the 12 September 2024 is as follows:

- For those WHCs received in 2018 there are 48 Complete
- For those WHCs received in 2019 there are 39 Complete
- For those WHCs received in 2020 there are 17 Complete
- For those WHCs received in 2021 there are 26 Complete
- For those WHCs received in 2022 there are 26 Complete, 3 Partially Complete, 1 Not Yet Due and 1 No Progress.
- For those WHCs received in 2023 there is 27 Complete and 1 No Progress
- For those WHCs received in 2024 there is 7 Complete, 5 Partially Complete, 5 Not Yet Due and 7 No Progress
- For those Ministerial Directions received in 2022 there is 1 Complete and 1 Not Yet Due
- For those Ministerial Directions received in 2023 there is 7 Complete

Welsh Health Circulars can be viewed here: Health circulars: 2024 to 2027 | GOV.WALES

Ministerial Directions can be viewed here: Publications | GOV.WALES

Please note Welsh Health Circulars and Ministerial Directions are reported on a calendar year.

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

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

DETAILED BACKGROUND AND ASSESSMENT:

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

The table below provides the Committee with an overview of the Welsh Health Circulars and Ministerial Directions that remain outstanding with No progress made. Updates will continue to be sought against these WHCs and reported to the Executive Committee and Audit, Risk and Assurance Committee.

WHC/MD Ref	Welsh Health Circular	Executive Lead	Status
2022 022	Role of the Community Dental Service and Services for vulnerable people	Director of Primary Care, Community and Mental Health	No Progress

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2023/003	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	Director of Nursing, Quality, Women and Family Health	No Progress
2024/004	Assurance of aseptic preparation of medicines in NHS Wales	Medical Director	No Progress
WG24-06	NATIONAL HEALTH SERVICE, WALES The National Health Service Joint Commissioning Committee (Wales) Directions 2024	Director of Finance, Capital & Support Services/ Medical Director	No Progress
2024/006	National Clinical Guideline for Stroke, for the UK and Ireland	Director of Therapies	No Progress
2024/016	Healthy Child Wales Programme: for school aged children	Director of Nursing, Quality, Women and Family Health	No Progress
2024/013	Governance on interim appointments to Executive and Senior Positions	Director of People and Culture	No Progress
2024/026	2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	Director of Finance, Capital, and Support Services	No Progress
2024/029	Certification of Vision Impairment in Primary and Community Care	Director of Primary Care, Community and Mental Health	No Progress
2024/027	All Wales Critical Care Escalation Guidance for the Management of All Large Unplanned Increased in Demand	Director of Planning, Performance and Commissioning	No Progress
2024/31	Agency Workforce reduction programme ad control framework 2024/2025	Executive Director of Finance and Capital and Support Services	No Progress

The following table provides an overview of the progress made against the implementation of WHCs received in 2018, 2019, 2020, 2021,2022 and 2023. The table also provides an update on the progress made against WHCs received in the 2024 year to date.

	2018	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Not Yet Due	0	0	0	0	1	0	5
No Progress	0	0	0	0	1	1	7
Partially Complete	0	0	0	0	3	0	5
Complete	48	39	17	26	26	27	7
TOTAL NUMBER ISSUED	**48**	**39**	**17**	**26**	**31**	**28**	**24**

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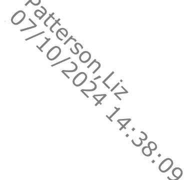
NEXT STEPS:
The Corporate Governance Team will continue to log and distribute Welsh Health Circulars and Ministerial Directions to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported on a bi-annual basis, the next update report is due to be presented in March 2025 to both Executive Committee and Audit, Risk and Assurance Committee.



WHC No.	Name of WHC	Lead Executive	Status	Comments
2022 022	Role of the Community Dental Service and Services for vulnerable people	Director of Primary Care, Community and Mental Health	No Progress	Recruited 1 WTE salaried GDP to provide routine GDS services, o.6WTE vacancy for specialist in special care dentisty. Looking to use a cloud based service to imporve IT record systems within the CDS. Recruitment of paeditatric specialist for 3 sessions per month to improve governance and service. Skill mixing using direct access therapists
2023/003	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	Director of Nursing, Quality, Women and Family Health	No Progress	Guideline due to be reviewed 1/05/2025. WHC emailed to Claire Roche, Claire Madsen, and Kate Wright and cc'd to Pas, Hayley Thomas, Louise Turner and Marie Davies on 5/04/2023. 06.02.24 update; PTHB paediatric medical lead is a member of the network that have developed the guidance. The Guidance has been reviewed within W and C policies, procedures and guidance group and is in the process of having a cover front sheet completed to be approved and uploaded to PTHB intranet.

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1MD	The Eye Health Examination Service Committee (Wales) Directions 2016	Director of Finance, Capital & Support Services/ Medical Director	No Progress	Duplicate of line 39
1MD	The Low Vision Service Committee (Wales) Directions 2016	Director of Finance, Capital & Support Services/ Medical Director	No Progress	Duplicate of line 40
2024/004	Assurance of aseptic preparation of medicines in NHS Wales	Medical Director	No Progress	

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WG24-06	NATIONAL HEALTH SERVICE, WALES The National Health Service Joint Commissioning Committee (Wales) Directions 2024	Director of Finance, Capital & Support Services/ Medical Director	No Progress	
2024/006	National Clinical Guideline for Stroke, for the UK and Ireland	Director of Therapies	No Progress	**September 2024.** As Stroke care in Powys is entirely about Post-Stroke rehabilitation rather than acute Stroke care this WHC is the remit of the Therapies Directorate.

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2024/016	Healthy Child Wales Programme: for school aged children	Director of Nursing, Quality, Women and Family Health	No Progress	
2024/013	Governance on interim appointments to Executive and Senior Positions		No Progress	

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2024/026	2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	Director of Finance, Capital and Support Services	No Progress	
2024/029	Certification of Vision Impairment in Primary and Community Care	Director of Primary Care, Commuity and Mental Health	No Progress	

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2024/027	All Wales Critical Care Escalation Guidance for the Management of All Large Unplanned Increased in Demand	Director of Planning, Performance and Commissioning	No Progress	
2024/31	Agency Workforce reduction programme ad control framwork 2024/2025	Executive Director of Finance and Capital and Support Services	No Progress	29.08.2024 - Wrongly allocated to People and Culture Exec Lead. It belongs to Finance. AMENDED and update requested

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WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
WG24-04	THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2024	08/02/2024	The Directions to Local Health Boards as to the Statement of Financial Entitlements Directions 2013(b) which came into force on 11 June 2013, as amended by Directions listed in Annex J of the Schedule to these Directions, are further amended as follows. Amendment of Part 1 Section 2 (Global Sum Payments) 3. In Part 1 Section 2 (Global Sum Payments)— (a) For paragraph 2.3 substitute— “2.3. Once the contractor’s CRP has been established, this number is to be adjusted by the Global Sum Allocation Formula, a summary of which is included in Annex B of this SFE. The resulting figure, which is the contractor’s Weighted Population for the quarter, is to be multiplied by £117.48 for the period beginning with 1 April 2023. For paragraph 2.4A substitute— (a) 2006 c. 42. (b) 2013 No. 8. 2 2.4A. £2.71 of the figure of £117.48 in paragraph 2.3 is to account for the agreed 5% increase in annual remuneration to practice staff employed by the GMS contractor and which GMS contractors must reflect as at least a 5% pay increase for those staff beginning with 1	Director of Finance, Capital & Support Services/ Medical Director	N/A	Complete	28.06.2024 - This has been fully implemented, as confirmed by Hywel Pullen

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2024/008	Vaccination against measles – urgent action	02/02/2024	Following the measles outbreak in Cardiff, I wrote to you in December (WHC(2023)043) with a reminder of the need to ensure that all staff working in healthcare settings should either have natural immunity to measles or have had a full 2-dose course of MMR vaccine. In that letter, I noted there was a growing risk of importations of the measles virus into Wales following increases across Europe. You will be aware of the serious outbreak in the West Midlands, and it is in that context I consider there is now a pressing need to take action to mitigate the possible impact on the Welsh population. Measles is a highly infectious disease which can only be controlled by vaccination. In 2017 the World Health Organisation (WHO) declared that the UK had eliminated measles. However, that status has not been maintained and measles will continue to pose a threat in Wales until the WHO target of 95% uptake of 2 doses of MMR vaccine by the age of 5 is achieved.	Director of Public Health	N/A	Complete	**September 2024.** The Medical Directorate has no direct role in this program. The following response has been provided by our colleagues in the Public Health Directorate. A working group was established to address the ask in the WHC. Occupational Health contacted all staff that records showed that they may be missing full course of MMR. Letters were sent out twice to remind staff to access MMR if they were not fully vaccinated. A suite of promotional actions were

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2024/009	COVID-19 spring booster vaccination programme 2024	N/A	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which has advised a spring COVID-19 booster vaccination should be offered to our most vulnerable citizens in 2024.The primary aim of the COVID-19 vaccination programme is the prevention of severe COVID-19 disease (hospitalisation and mortality). Health boards are expected to continue to maximise vaccine uptake, minimise vaccine waste, retain their focus on reaching the most vulnerable, and understand and address inequity by ensuring access for all eligible people. With this in mind, we expect: 1. All those eligible for a spring booster to receive an invite for vaccination; 2. Health boards should make every effort to maximise uptake across all cohorts ensuring that; i. uptake levels are maintained or improved for those over 75 years of age and those resident in a care home for older adults, and that every effort is made to achieve 75% uptake for these cohorts; ii. by taking account of the challenges faced in encouraging the immunosuppressed to come forward, all possible interventions which could improve uptake for this cohort are explored and any barriers to vaccination are removed; iii. the gap is reduced between uptake rates1 in the least and most deprived areas of the health board.	Director of Public Health	N/A	Complete	**September 2024.** The Medical Directorate has no direct role in this program. The following response has been provided by colleagues from the Public Health Directorate. Vaccination service delivered on the Spring 2024 Covid-19 WHC between 01 April 2024 – 30 June 2024 (some catch ups were permitted until 31 July 2024). 22405 eligible patients were invited to recieve the vaccine. A total of 15,120 vaccinated, an uptake of 67.5% 407 attended but couldn't be

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2024/010	The NHS Welsh Sustainability Conference and Awards	27/02/2024	In 2019 the Welsh Government declared a climate emergency for Wales to help trigger more focus and greater action to meet the challenges presented by the climate crisis. Wales has a legally binding target to deliver the goal of net-zero emissions by 2050, alongside an ambition for the public sector in Wales to be collectively net zero carbon by 2030. In 2018/19 the NHS Wales Carbon Footprint was estimated to be 1,001,378 tCO2e, and these 'health emissions' are approximately 2.6% of Wales' total emissions. Although the Welsh Government has established the Health and Social Care Climate Emergency National	Director of Finance, Capital & Support Services/ Medical Director	10/05/2024	Complete	**September 2024.** This conference was noted but it wasn't felt that it was beneficial for there to be any attendees from the Medical Directorate. The conference took place in June 2024
2024/019	Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales (Reissue)	23/04/2024	Amendment the Model Standing Orders and Reservation and Delegation of Powers for the organisation following the establishment of the NHS Wales Joint Commissioning Committee. On 1 April 2024 the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) will cease to exist. They are to be replaced by the NHS Wales Joint Commissioning COmmittee. The new Joint Commissioning	Director of Coporate Governance	Oct-24	Complete	04.09.24 update - Standing Orders amended as approved by the Board

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2024/025	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25	04/06/2024	To ensure the maximum benefit is derived from the clinical audit programme health boards and trusts should: • Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan. • Appoint a clinical lead to act as a champion and point of contact for every National Clinical Audit and Clinical Outcome Review Programme, which the health board is participating in. Health boards and trusts should also encourage and support clinical leads to take on the role of all-Wales representative on audit steering groups and networks where required. • Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendations are identified. • Have clear lines of communication, which ensures full board engagement in the consideration of audit and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place. • Work with DHCW to facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.	Director of Coporate Governance		Complete	04.09.24 update - complete, resources in place. Medical Director the named clinical lead. Director of Corporate Governacen the named lead for internal audit and Audit Wales (together with the Director of Finance for external financial audits)

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2024/32	Introduction of new NHS Wales vaccination programmes against respiratory syncytial virus (RSV)	24/06/2024	Health boards are expected to maximise vaccine uptake, minimise vaccine waste, retain their focus on reaching the most vulnerable, and understand and address inequity by ensuring access for all eligible people. With this in mind, we expect: 1. All those eligible to receive an invite for an RSV vaccination in a timely manner: I. For older adults, the aim should be for invitations for vaccination to be made within 12 weeks of individuals turning 75; II. For pregnant women, vaccination should be offered at their 28 week antenatal appointment, with vaccination available until discharge from midwifery services. 2. Health boards should	Director of Public Health	N/A	Complete	23.08.2024 - Plans developed in line with WHC. Implementation commencing September 2024.

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Audit, Risk and Assurance Committees 2024-25

Theme	Item Title	May 14/05/2024	July 09/07/2024 (Annual accounts)	Oct 8/10/24	Jan 14/01/2025	March 11/03/2025
Governance	Minutes of previous meeting	✓	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓	✓
Governance	Annual Work Programme	✓				
Governance	Work Programme (updated through year)		✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness					✓
Governance	Committee Annual Report	✓				
Governance	Audit Recommendation Tracker	✓	✓	✓	✓	✓
Governance	WHC Tracker			✓		✓
Governance	Register of Interests			✓		
Governance	Register of Gifts and Hospitality			✓		✓
Governance	Board Assurance Framework			✓		
Governance	Review of Terms of Reference					✓
Governance	Review of Standing Orders and Standing Financial Instructions	✓				✓
Governance	Confirmation Clinical Audit Programme in place		✓			
Annual Accounts	Approach to the Annual Accounts					✓
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	✓				
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation		✓			
Internal Audit	Head of Internal Audit Opinion Draft	✓				
Internal Audit	Head of Internal Audit Opinion Final		✓			
Internal Audit	Internal Audit Annual Plan					✓
Internal Audit	Internal Audit Progress Report 24/25	✓	✓	✓	✓	
Internal Audit	Internal Audit Reports (as required)	✓	✓	✓	✓	✓
Internal Audit	Internal Audit Trend Report				✓	
External Audit	Enquiries of Management and Those Charged with Governance		✓			
External Audit	External Audit Annual Plan					✓
External Audit	External Audit Progress Report	✓	✓	✓	✓	
External Audit	External Audit Reports (as required)	✓	✓	✓	✓	✓
External Audit	Structured Assessment				✓	
Counter Fraud	Counter Fraud Annual Plan					✓
Counter Fraud	Counter Fraud Update	✓	✓	✓	✓	
Counter Fraud	Counter Fraud Reports (as required)	✓	✓	✓	✓	✓
Finance and Procurement	Single Tender Waivers Annual Report	✓				
Finance and Procurement	Single Tender Waivers (including extensions to contracts)	✓	✓	✓	✓	✓
Finance and Procurement	Losses and Special Payments Annual Report	✓				
Finance and Procurement	Losses and Special Payments			✓		✓
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Oct	✓		Moved to ARAC January 2025		
Risk	Review of Risk Management Framework			✓		
Risk	Assurance of Risk Management arrangements	✓				
Hosted Bodies	Hosted Body annual report (HCRW)		✓			
Information Governance	IG Annual Report					
Information Governance	IG Performance Report			√	√	
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)					
Information Governance	Records Management Improvement Plan (Escalated issue)				√	
Key						
Date to be confirmed						
Item to be confirmed						
Item deferred						
Item brought forward						
Going to Board						
Due to Committee						
Find Exec Cttee date						
Added to draft agenda						