Audit, Risk and Assurance Committee

Mon 11 March 2024, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARA_Agenda_11 March 24.pdf (2 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *All*

1.3. Minutes from the previous meeting held on 16 January 2024 for approval

Attached *Chair*

ARAC _Item_1.3_Unconfirmed_Minutes_16 January 2024.pdf (12 pages)

1.4. Committee Action Log

Attached *Chair*

ARAC_Item_1.3a_Action Log March 2024.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

Attached *Director of Finance, Information and IT*

ARAC_Item_2.1_Application for Single Tender Waiver March 24.pdf (2 pages)

2.2. Internal Audit Annual Plan 2024-2025

Attached *Head of Internal Audit*

ARAC_Item_2.2_Internal Audit Plan 2024-25 Cover.pdf (3 pages)
ARAC_Item_2.2a_Internal Audit Plan 2024-25.pdf (29 pages)

2.3. External Audit Annual Plan 2024-2025

Deferred to May 2024

2.4. Counter Fraud Annual Plan 2024-2025

Attached *Head of Local Counter Fraud*

ARAC_Item_2.4_ Counter Fraud Work Plan 2024-25.pdf (3 pages)
ARAC_Item_2.4a_Counter Fraud Work Plan 2024-25.pdf (9 pages)

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Approach to Annual Accounts 2023-2024

Attached *Director of Finance, Information and IT*

ARAC_Item_3.1b_NHS letter - final 23-24.pdf (10 pages)
ARAC_Item_3.1a_Approach to 23-24 Annual Accounts ARA 11MAR24.pdf (12 pages)

3.2. Internal Audit Reports:

Attached *Head of Internal Audit*

ARAC_Item_3.2_ Internal Audit Progress Report March 24 Cover.pdf (4 pages)
ARAC_Item_3.2a_ Internal Audit Progress Report March 24.pdf (12 pages)

3.2.1. Primary Care Dental Services – Management and Monitoring of GDS Contracts – final report (Substantial Assurance)

Attached

ARAC_Item_3.2b_ Final Internal Audit Report - Primary Care - GDS Contracts.pdf (11 pages)

3.2.2. Board and Committee Structure/Effectiveness – final report (Substantial Assurance)

Attached

ARAC_Item_3.2c_Board& Committee Structure Effectiveness Final Report.pdf (10 pages)

3.2.3. IT Infrastructure and Asset Management – follow up (Reasonable Assurance)

Attached

ARAC_Item_3.2d_IT infrastructure follow up final report.pdf (18 pages)

3.2.4. Cyber Security – follow up (Reasonable Assurance)

Attached

ARAC_Item_3.2e_Cyber Security follow up final IA report.pdf (8 pages)

3.2.5. Estates Condition – final report (Limited Assurance)

Attached

ARAC_Item_3.2f_Estates Condition Final Audit Report.pdf (27 pages)

3.3. External Audit Progress Reports

Attached *Audit Wales*

ARAC_Item_3.3_Audit Wales ARAC Update March 2024.pdf (12 pages)

3.3.1. Structured Assessment

ARAC_Item_3.3a_THB Structured Assessment 2023 Report.pdf (36 pages)

3.3.2. Workforce

ARAC_Item_3.3b_Workforce planning report _FINAL with org response.pdf (34 pages)

3.3.3. External Audit - Annual Audit Report

ARAC_Item_3.3c_ External Audit Annual Audit Report 2022-23.pdf (22 pages)

3.4. Audit Recommendation Tracker

Attached *Director of Corporate Governance*

ARAC_Item_3.4_Audit Recommendations_Report_Feb 24.pdf (3 pages)
ARAC_Item_3.4a_App 1 Internal Audit Recs that REMAIN outstanding v2.pdf (4 pages)

ARAC_Item_3.4b_App 2 Internal Audit Recs that COMPLETED since the previous report.pdf (2 pages)
ARAC_Item_3.4c_App 3 Internal Audit Recs NOT YET DUE for implementation.pdf (2 pages)
ARAC_Item_3.4d_App 4 External Audit Recs that REMAIN outstanding.pdf (1 pages)
ARAC_Item_3.4e_App 5 External Audit Recs COMPLETED since the previous report.pdf (1 pages)

3.5. Welsh Health Circular Tracker

Attached *Director of Corporate Governance*

ARAC_Item_3.5_Welsh Health Circular.pdf (4 pages)
ARAC_Item_3.5a_Appendix 1 WHCs and MDs that remain outstanding.pdf (2 pages)
ARAC_Item_3.5b_Appendix 2 WHCs Implemeted since previous.pdf (7 pages)

3.6. Board Assurance Framework

Attached *Director of Finance, Information and IT*

ARAC_Item_3.6_BAF.pdf (9 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

4.1. Annual Assessment of Committee Effectiveness

Attached *Director of Corporate Governance*

ARAC_4.1_ Committee effectiveness March 2024.pdf (20 pages)

4.2. Review of Terms of Reference

Attached *Director of Corporate Governance*

ARAC_Item_4.2a_ARAC Terms of Reference.pdf (12 pages)
ARAC_Item_4.2_Review of Committee Terms of Reference.pdf (4 pages)

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Committee Work programme

Attached *Director of Corporate Governance*

ARAC_Item_5.1_ARAC work plan March 2024.pdf (2 pages)

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

Oral *Chair*

5.3. Any Other Urgent Business

Oral *Chair*

5.4. Date of next meeting:• 14 May 2024 at 10.00, Microsoft Teams

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
MONDAY 11 MARCH 2023
10.00 – 12.00
VIA MICROSOFT TEAMS

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

AGENDA

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the previous meetings held 16 January 2024	Attached	Chair
1.4	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1 10.05	Application of Single Tender Waiver	Attached	Director of Finance, Information and IT
2.2 10.10	Internal Audit Annual Plan 2024-25	Attached	Head of Internal Audit
2.3	External Audit Annual Plan 2024-25 (deferred)	-	Audit Wales
2.4 10.20	Counter Fraud Annual Plan 2024-25	Attached	Head of Local Counter Fraud
3	**ITEMS FOR ASSURANCE**		
3.1 10.30	Approach to the Annual Accounts 2023-24	Attached	Director of Finance, Information and IT
3.2 10.35	Internal Audit Reports: • Primary Care Dental Services – Management and Monitoring of GDS Contracts – final report (*Substantial Assurance)* • Board and Committee Structure/Effectiveness – final report (*Substantial Assurance*) • IT Infrastructure and Asset Management – follow up (*Reasonable Assurance*) • Cyber Security Follow Up (*Reasonable Assurance)* • Estates Condition – final report (to follow) (*Limited Assurance*)	Attached	Head of Internal Audit
3.3	External Audit Reports:	Attached	Audit Wales

11.00	• Audit Wales ARAC update • Structured Assessment • Workforce Planning • Annual Audit Report 2023		
3.4 11.20	Audit Recommendation Tracking	Attached	Director of Corporate Governance
3.5 11.25	Welsh Health Circular Tracker	Attached	Director of Corporate Governance
3.6 11.30	Board Assurance Framework	Presentation	Director of Corporate Governance
4	**ITEMS FOR DISCUSSION**		
4.1 11.40	Annual Assessment of Committee Effectiveness	Attached	Director of Corporate Governance
4.2 11.55	Review of Terms of Reference	Attached	Director of Corporate Governance
5	**OTHER MATTERS**		
5.1	Committee Work Programme	Attached	Director of Corporate Governance
5.2	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.3	Any Other Urgent Business	Oral	Chair
5.4	Date of the Next Meeting: • 14 May 2024 at 10.00, Microsoft Teams		

Key:

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

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

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 16 JANUARY 2024 VIA MICROSOFT TEAMS

Present:

Rhobert Lewis	Independent Member (Chair)
Kirsty Williams	Independent Member
Chris Walsh	Independent Member (Local Authority)

In Attendance:

Steve Elliot	Independent Financial Advisor
Pete Hopgood	Director of Finance and IT and Interim Deputy Chief Executive
Hayley Thomas	Chief Executive Officer
Sarah Pritchard	Head of Financial Services
Helen Bushell	Director of Corporate Governance/Board Secretary
Bethan Hopkins	Audit Wales
Mike Jones	Audit Wales
Ian Virgil	Head of Internal Audit
Martyn Lewis	Internal Auditor
Matthew Evans	Head of Local Counter Fraud

Observers

None

Committee Support

Elizabeth Patterson	Interim Head of Corporate Governance

Apologies

Ronnie Alexander	Independent Member
Alice King	Audit Wales
Kirsten Jones	Llais
Hywel Pullen	Deputy Director of Finance
Jayne Gibbon	Internal Audit Manager

ARA/23/053	**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/23/054	**DECLARATIONS OF INTEREST** No interests were declared in addition to those already declared in the published register.
ARA/23/055	**MINUTES OF THE MEETINGS HELD 10 OCTOBER 2023** The minutes of the meetings held on 10 October 2023 were AGREED as a true and accurate record.
ARA/23/056	**COMMITTEE ACTION LOG** The Committee received and ACCEPTED the Action Log. The following action remained open: • ARA/23/041a – The Director of Finance, Information and IT undertook to obtain a response from the Commissioning team
ARA/23/057	**APPLICATION OF SINGLE TENDER WAIVER -INCLUDING RE PROVISION OF ORTHODONTIC TREATMENT** The Head of Financial Services presented the report noting there had been one Single Tender Waiver application made between 1 October 2023 and 31 December 2023. Committee Members and Financial Advisor asked the following questions for assurance: *With regard to the Single Tender Waiver for Occupational Health, which has been extended. Is there a long-term plan for this contract?* The Head of Financial Services advised that there was a national programme examining the potential of a central Occupational Health Service. The Single Tender Waiver will address the immediate needs of the Health Board. *Given this Single Tender Waiver only runs to 31 March 2024 might it be necessary to process an additional one?* The Head of Financial Services confirmed this would potentially be the case unless the post is successfully recruited to, or progress is made with the national programme. The Committee RATIFIED the use of Single Tender Waiver in respect of this item during the period of 1 October 2023 and 31 December 2023.
ARA/23/058	**INTERNAL AUDIT PROGRESS REPORT 2023-24** The Head of Internal Audit presented the report which provided 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.

The following matters were highlighted for the Committee's attention:

- Since the last meeting of the Committee five audits had been finalised and report completed which reported in the next agenda item

- There had been a total of 22 audit reviews included with the 2023/24 Internal Audit Plan. At the time of reporting, six audits had been finalised with a further two at the draft report stage, three audits were currently work in progress with a further 11 at the planning stage.

- The following proposed changes were proposed:
  - The Efficiency Framework/Value Board audit be removed due to an overlap with existing audits;
  - Staff Recruitment and Retention audit be removed due to the current focus on reducing staff costs for the current and next financial year. This to be replaced with a national audit on decarbonisation plans; and
  - Partnership Governance Framework audit to be deferred to 2024/25.

- The 2024/25 Internal Audit Plan is in development and will be brought to the March meeting of the Committee for formal approval.

The Committee Members and Financial Advisor asked the following questions for assurance:
The draft Capital and Estates audit is showing 'Limited Assurance'. Is the Health Board picking up on emerging themes?
The Head of Internal Audit advised that the report had been subject to in depth discussion with Service Managers and the Director of Corporate Governance to finalise the report. Management was aware of key areas and are working on an action plan.

The Director of Corporate Governance advised there had been some dispute regarding the assurance rating of the audit, further discussions were underway and would be reported to the next Committee meeting.

If agreement cannot be found for this audit can the areas of disagreement be made clear?
The Head of Internal Audit advised that it was hoped an agreed position would be reached, but if this is not possible the areas of disagreement will be highlighted.

What happens next with audits with a Low Assurance outcome?

	The Head of Internal Audit advised that the individual recommendations are tracked by the Health Board, and this is monitored by the Committee. Any areas receiving a Low Assurance outcome will be subject to a follow-up audit the following year. *It can be seen that much of the work takes place during Quarter 3 and 4 which is when the organisation tends to be under particular pressures. When the plan is agreed for 2024/25 can this be taken into account?* The Head of Internal Audit advised that when the 2023/24 plan was agreed, the uneven nature of work across the year was noted and Internal Audit have provided appropriate resource to be able to complete the volume of work scheduled. Engagement with the Health Board is good for both planning and field work. If any issues arise, these are flagged with the Director of Corporate Governance. The Director of Corporate Governance drew attention to page 10 of the report where a Red Rating is shown in relation to response times to audit reports. This related to the Information Governance report with a proposed 'Low Assurance' rating and is due to the discussion that is required to agree the final report. It is expected that the Capital and Estates audit will also have a Red Rating for report response times. *Is the delayed Partnership Governance Framework specific to the Health Board or an all Wales Framework?* The Director of Corporate Governance advised this was specific to the Health Board and included partners such as the Local Authority, Third Sector and Commissioning partners. The Committee: • NOTED the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports; and • APPROVED the proposed adjustments to the 2023/24 plan, namely, to remove the following audits from the plan: o Efficiency Framework/Value Board o Staff recruitment and retention o Partnership Governance Framework.
ARA/23/059 Mills,Belinda 11/03/2024 17:12:59	**INTERNAL AUDIT REPORTS:** a. Business Continuity Planning (Substantial Assurance) The Head of Internal Audit presented the report which sought to establish if the Health Board has appropriate arrangements in place to ensure effective business continuity plans at corporate level. The report confirmed a substantial assurance with one low priority action

identified.

The Committee Members and Financial Advisor asked the following questions for assurance:
IT resilience is specifically excluded from this audit. Where will this be audited?
The Head of Internal Audit advised this would be subject to consideration for the draft Audit Plan 2024/25.

The Director of Corporate Governance advised that IT resilience is an issue that is tracked via the Delivery and Performance Committee.

b. Clinical Education – HCSW Induction Programme (Reasonable Assurance)

The Head of Internal Audit presented the report which sought to review the Health Board's arrangements in place for the first part of the deployment of the Framework which is a focused review of the induction programme to establish if effective processes are in place to ensure compliance with the requirements of the Framework.

The report confirmed a reasonable assurance, five actions had arisen, four were of medium priority and one of high priority.

The Committee Members and Financial Advisor asked the following questions for assurance:
The high priority matter arising in relation to Monitoring and Reporting is important given the low numbers and the focus on this is welcomed.
The Director of Corporate Governance confirmed this would be monitored via the Audit Recommendation Tracker

c. Health and Safety Arrangements (Reasonable Assurance)

The Head of Internal Audit presented the report which sought to review and assess the adequacy of the processes in place within the Health Board to ensure compliance with Health & Safety legislation.

The report confirmed a reasonable assurance with three actions identified, two having medium priority and one having high priority.

The Committee Members and Financial Advisor asked the following questions for assurance:
Different organisations place the responsibility for ensuring appropriate training with either Managers or Health and Safety leads. Do Managers have the skills to know what training requirements are?
The Head of Internal Audit confirmed that the focus had been on ascertaining if management had undertaken a review of training

requirements and then had processes in place to ensure this was delivered.

The Director of Corporate Governance advised that the Delivery and Performance Committee would be considering the Annual Health and Safety Report where Audit, Risk and Assurance Committee may suggest an update on the audit recommendations is received.

The Chair agreed with this proposal.
Action: Director of Therapies and Health Sciences

d. Incident Management (Reasonable Assurance)

The Head of Internal Audit presented the report which sought to review the arrangements in place within the Health Board for the identification, recording, investigation, and management of incidents. The review also focused on the Health Board's ability to learn from incidents and take action to improve processes whilst sharing best practice across the Health Board. Last year a similar audit had been undertaken for Community Services, this year the audit focussed on Women and Children's and Mental Health Services.

The assurance remained the same as last year and it was recognised that progress had been made in relation to organisational arrangements for incident management and developing policies, procedures and a framework for incident management. However, the report identifies areas for improvement specifically within the service area subject to the audit.

The report confirmed a reasonable assurance, four actions were identified, three medium priority and one high priority.

The Committee Members and Financial Advisor asked the following questions for assurance:
The Chair of Patient Experience, Quality and Safety Committee advised that incident management was an area that was being considered by the Committee next week in relation to Mental Health. The connections between incident management and the Duty of Quality and Candour were being made.

What is causing the delay in incident reporting and investigating. Will there be improvement?
The Chief Executive advised that she was sighted on the improvement work required and that it would be necessary to look at this across the organisation. This was work in progress. In relation to the backlogs in Mental Health, there has been improvement, but any backlog is unacceptable, and a plan is in development to clear the backlog and ensure it does not recur. The service will need support to achieve this position and whilst there were

staffing challenges in the team around the time of the audit there is a question as to a need to escalate in such circumstances. The organisation will need to ensure that progress is made across the organisation not just on a team by team basis.

The Chief Executive confirmed that the Patient Experience, Quality and Safety Committee as well as the Executive Committee was closely monitoring the backlog of incidents in Mental Health to the next meeting.

e. Information Governance (Limited Assurance)

The Internal Auditor presented the report which sought to review the adequacy of the resourcing, capacity, and resilience of the Information Governance structures to achieve compliance with UK GDPR and FoI requirements, and completion of the IG Toolkit. Whilst the Health Board had increased resource to this area, demand was also increasing both in numbers of requests and the complexity of requests. The team are acting primarily in a reactive way with little resilience to progress other areas of work, and it is not clear who information asset owners are which leads to problems for the team.

The report confirmed a limited assurance, of the four key matters arising two were found to be of medium priority and two of high priority.

The Committee Members and Financial Advisor asked the following questions for assurance:
It is not possible to continually increase resource to meet demand. What can be done to manage demand?
The Internal Auditor noted that all organisations were seeing an increase in demand as patients understood how easy it was to submit a request.

The Financial Advisor noted that capacity was managed by Fixed Terms Contracts that would not be reviewed if demand fell. However, reductions in demand appeared unlikely.

Is best practice being used to identify ways of improving the information asset register?
The Chief Executive cautioned that the resources available needed to be balanced between clinical and non-clinical services and that best practice should be sought to enable the service to increase capacity.

At what point will this become a risk that cannot be ignored, and the situation gets out of control?
The Director of Corporate Governance confirmed that the Committee will track the recommendations via the Audit Recommendation Tracker, the Delivery and Performance Committee will monitor the Information

	Governance Improvement Plan, and the Director of Finance, Information and IT will lead on resourcing the service. The Committee NOTED the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
ARA/23/060	**INTERNAL AUDIT THEMES AND REFLECTIONS** The Head of Internal Audit presented the report which provided the Committee with information regarding trends and themes that can be identifed through the analysis and review of the outcomes form previous Internal Audits, in order to help inform potential areas of future focus and scrutiny by Internal Audit and the Committee as well as relfections and learning for the organsiation. It was highlighted that the slides within the presentation 'Internal Audit themes and reflections' provide an analysis of the Internal audit work that has been completed for the Health Board over the last 6 years (From 18/19 through to 23/24 to mid-December when the report was prepared), along with some comparison to the work completed for all NHS organisations within Wales. Overall it was found that the trends and outcomes for the Health Board were similar to the all Wales position although the Health Board have had slightly more Limited than Substantial ratings than the all Wales average. However, this may be skewed by the low number of audits that are undertaken in the Health Board against the much larger number undertaken in the bigger Health Boards. Audit work is structured over the following 8 domains: 1. Workforce management 2. Strategic Planning, performance management and reporting 3. Operational service and functional managemetn 4. Information governance and security 5. Financial governance and management 6. Corporate Governance, Risk and Regulatory Compliance 7. Clincial Governance, quality and safety 8. Capital and estates The period examined was 2018-2023 and it was found that the Health Board had Limited or No assurance reports primarily in Information Governance and Security, Corporate Govenance and Capital and Estates compared to the all Wales position where Limited and No assurance reports were found across all domains. Of the 106 audits undertaken (not including advisory audits) a total of 462 recommendations were made with an average of 4.36 recommendations. The recommendations are grouped into 24 themes with the top 8 identified

	as: 1. Compliance 2. Reporting 3. Policies and procedures 4. Governance and risk managemetn 5. Audit trail (documentation) 6. Ineffective controls 7. Finances and resourcing 8. Training and development Examples of themes were shared for Capital and Estates and Information Governance. A demonstration of the live data base was offered to a future meeting. The Committee Members and Financial Advisor asked the following questions for assurance: *The possibility of the results of the audits from the Health Board being skewed as more audits are undertaken in other Health Boards was mentioned. However, it appears that a large number of audits have been undertaken in the Health Board, is it proportionate?* The Head of Internal Audit noted there was a balance to be struck between the number and depth of audits, however, a sufficient number of audits was necessary to enable the Annual Internal Audit Opinion to be given. The Chief Executive advised that the Annual Audit Plan would require careful scrutiny to ensure a proportionate approach along with the possibity of extending the programme over a 5 year period in tandem with the 5 Year Plan. It will be necessary to reflect on the prominence of compliance and procudure themes in the audit recommendations to ensure that the necessary actions are undertaken to address this. The Director of Corporate Governance advised that consideration is being given to be best way of sharing information regarding audit and inspections outcomes with the Board. An initial discussion will take place at Board Development. The Committee: • CONSIDERED the themes and reflections highlighted through the analysis of the outcomes of previous Internal Audit work.
ARA/23/061	**AUDIT RECOMMENDATION TRACKING** The Director of Corporate Governance presented the report which provided the 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 30 November 2023. The report confirmed that there are 57 overdue internal audit recommendations of which 32 relate to the current or previous year and 25 relate to the years 2019-2022. 14 of these recommendations are defined as high priority. The Executive Committee considered the report in December and agreement made to focus on closing overdue recommendations. There is an element of covid related legacy in relation to some of the longer overdue recommendations. A further 8 recommendations have been closed but have missed the reporting timeframe prior to publication of the agenda papers. In relation to External Audit there remain 8 outstanding recommendations and there are no outstanding recommendations for Counter Fraud. The Chair welcomed the focus on closing long overdue recommendations and looked forward to receiving an improved position in the next report. 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/23/062	**EXTERNAL AUDIT PROGRESS REPORT 2023-24** The External Audit Manager presented the report which provided an update on the current and planned accounts and performance audit work at Powys Teaching Health Board: <u>Accounts audit update:</u> • Audit of the 2022-23 Accountability Report and Financial Statements – Audit completed. • Audit of the Charitable Funds Financial Statements – there has been some delay in obtaining an assurance report from Fund Managers which may affect the ability to meet the statutory deadline of 31 January 2024. The Director of Corporate Governance confirmed the Board Meeting to approve the Charitable Fund accounts had been postponed and that the Fund Manager issue affected a number of NHS Wales organisations. Missing the Charity Commission deadline for submission of accounts was of concern and the Health Board looked to Audit Wales to support an explanation of the missed deadline. The Audit Wales representative advised that consideration was being given to the possibility of Audit Wales verifying the fund, however, the extent and cost of this potential course of action would need to be ascertained.

	Performance audit update: • Review of unscheduled care – Part 1 Field work is completed, and the report is in draft with a final report due to Committee in March 2024. Part 2 project brief issued due to commence in March 2024. • Primary Care Services Follow-up Review – Report will be issued next week and will be brought to Committee in March 2024 • Workforce Planning - Report will be issued this week and will be brought to Committee in March 2024 • Structured Assessment - Core Comments on the draft report are due in shortly and the final report will be brought to Committee in March • Structured Assessment 2023 - Deep Dive – Fieldwork is underway, and the report will be brought to Committee in March 2024 • The All-Wales thematic review of planned care is in the planning stage • Local work has not yet started. The Committee thanked Audit Wales for the report and DISCUSSED and NOTED the Report.
ARA/23/063	**COUNTER FRAUD UPDATE** The Head of Local Counter Fraud presented the report which provided an update on the key areas of work undertaken by the Counter Fraud Specialists during 2023/24. The level of activity had been impacted by long term sickness absence with the postholder returning in January 2024. Consideration is being given to strategic governance arrangements for counter fraud services in Wales which is expected to go to consultation shortly. The service is continuing to receive notifications of suspected fraud with no real patterns emerging. The types of frauds being reported are working whilst on sick leave and contractor fraud with examples provided in the appendix to the report. The Committee Members and Financial Advisor asked the following questions for assurance: *Given the staffing challenges outlined in the report, is casework up to date or is there a backlog?* The Head of Local Counter Fraud advised that all cases had been investigated although this had taken longer the team member been in post. *Are the number of cases identified in Powys proportionally similar to other Health Boards?* The Head of Local Counter Fraud confirmed this was the case. The Committee: • RECEIVED the report for discussion; and • Took ASSURANCE that appropriate counter fraud systems are in place.
ARA/23/064	**REGISTER OF INTEREST AND REGISTER OF GIFTS AND HOSPITALITY** The Director of Corporate Governance presented the report which provided the latest position for Register of Interests for Independent Members and

	Executive Directors at 31 December 2023, and the Register of Gifts and Hospitality for Board members and employees at December 2023. It was noted that a small number of colleagues included on the Register were no longer Members of the Board. It was correct that they remain on the Register for the year during which they were Board Members, but that the register should indicate when they ceased to be a Board Member. The notification of receipt of gifts and hospitality was welcomed but it was acknowledged it would be necessary to do more to communicate the requirement to make declarations where appropriate. The Committee: • RECEIVED the contents of Register of Interests and Register of Gifts and Hospitality for PTHB Board Members at 31 December 2023, and; • Took ASSURANCE that the organisation has appropriate processes to support the collection, management and reporting of declarations of interest, in line with the Standards of Behaviour Policy.
ARA/23/065	**COMMITTEE WORK PROGRAMME** The Director of Governance noted that it was likely that there would be a number of audit reports to be brought to the March meeting and gave assurance that the agenda would be appropriately managed to accommodate this. The Committee RECEIVED and NOTED the Committee Work Programme.
ARA/23/066	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The following matters were to be brought to the attention of Delivery and Performance Committee and PEQS
ARA/23/067	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/23/068	**DATE OF NEXT MEETING** 12 MARCH 2024 at 10:00, Microsoft Teams

Audit and Risk Assurance Committee

RAG Status:	
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

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								
10-Oct-23	ARA/23/041a	Director of Finance and IT	Internal Audit Reports	Response requested to 'Why does it take 2-3 months to ensure payment is only made for sessions provided (Internal Audit on SLAs). Response to be brought to January 2024 meeting	**16.01.24 update in the meeting :** DFIT to obtain a response from the Commissioning Team **11.03.24 update** - verbal update will be provided during the meeting	Jan-24	11.03.24	On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 11 MARCH 2024)								
16/01/2024	ARA/23/59	Director of Therapies and Health Sciences	Internal Audit Reports	Delivery and Performance Committee to receive update on organisational response to Health and Safety Internal Audit	**11.03.24 update** - Item transferrred to the D&P action log for the Committees next meeting in May			Transferred

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 11 March 2024**
Subject:	**SINGLE TENDER WAIVERS**
Approved and presented by:	Interim Deputy CEO / Director of Finance, Information and IT
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 January 2024 and 29 February 2024.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there have been no Single Tender Waiver requests made between 1 January 2024 and 29 February 2024.

Ratification	Discussion	Information
✓		

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its January 2024 meeting which covered the period from 1 October 2023 and 31 December 2023.

No Single Tender Waiver Requests have been received between the period 1 January 2024 and 29 February 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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 2.2

Audit, Risk and Assurance Committee	**Date of Meeting: 11 March 2024**
Subject:	**Draft Internal Audit Plan 2024/25**
Approved and Presented by:	Board Secretary / Head of Internal Audit
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To present the draft Internal Audit Plan for 2024/25 to the Committee for review, comment and approval.

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

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Approve** the Internal Audit plan for 2024/25.
- **Approve** the Internal Audit Charter as at March 2024.

- **Note** the associated Internal Audit resource requirements and Key Performance Indicators.

Approval	Discussion	Information
X	X	

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

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

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

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

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

The Internal Audit Charter has been updated as at March 2024 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

NEXT STEPS:

Progress towards delivery of the Internal Audit plan will be reported to each meeting of the Committee during 2024/25.

EXECUTIVE SUMMARY:

The draft Internal Audit plan for 2024/25 has been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents.

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

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

The plan covers the whole of the 2024/25 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

Annual Internal Audit Plan: Draft Internal Audit Charter

March 2024

Powys Teaching Health Board

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

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

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

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

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

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

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

2.2 Risk based internal audit planning approach

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

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

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

We will ensure that the plan remains fit for purpose by recommending

changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Charter.

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

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

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

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

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

3) Follow up: this is follow-up work on previous limited and unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

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

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

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

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

2.3 Link to the Health Board's systems of assurance

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

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

2.4 Audit planning meetings

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

The draft Plan has been provided to the Health Board's Executive Committee to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

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

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

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

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

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

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

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

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

4.2 Keeping the plan under review

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

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

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan

to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audi, Risk and Assurance Committee for approval.

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

5. Resource needs assessment

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

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the health board will need to pay an additional £72,635 (£64,325 in 23/24) to cover this additional audit work.

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

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

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

Under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. Noting the anticipated profile of activity within the Health Board during 2024/25, this additional charge is £34,045 (£14,367 in 23/24).

The audit of major programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective approved business cases with the associated plans funded via the Welsh Government's capital allocations. There are currently no health board projects proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2024/25.

Therefore, the Health Board will be charged an additional amount of £106,680 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2024/25.

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

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

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Risk Management & Assurance	1		Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	Director of Corporate Governance	Q4
Board Effectiveness	2		Review and evaluate the operation of the Health Board's Board to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	Director of Corporate Governance	Q3
Policy Management	3		Review the arrangements and processes in place for the creation, management and review of Health Board policies.	Director of Corporate Governance	Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medicines Management	4		Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing. Exact scope of audit to be agreed.	Medical Director	TBC
Cancer Services	5	CRR 005	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.	Medical Director	Q3/4
Patient Flow / Discharge Management	6	CRR 004	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.	Director of Operations / Community & Mental Health	Q1/2
Mental Health Care and Treatment Planning	7	CRR 005	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.	Director of Operations / Community & Mental Health	Q2/3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Local Primary Mental Health Support Services	8	CRR 005	Review of how the Local Primary Mental Health Support Services are structured, managed and delivered.	Director of Operations / Community & Mental Health	Q4
Quality & Safety Governance (Duty of Quality)	9	CRR 003	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. Exact scope to be agreed.	Director of Nursing & Midwifery	Q4
Deprivation of Liberties Safeguards (DoLS)	10		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.	Director of Nursing & Midwifery	Q3
Staff Retention	11	CRR 006	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.	Director of Workforce & Organisational Development	Q2/3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Partnership Governance Framework	12	CRR 007	Review of the development and implementation of the Framework.	Director of Performance & Commissioning / Director of Corporate Governance	Q4
IMTP / Annual Plan Development	13	CRR 001 / 008	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	Director of Performance & Commissioning	Q1
Procurement & Contract Management (All Wales Review)	14	CRR 001	To provide assurance that the Health Board has appropriate procurement and contract management arrangements in place. Review of Health Board arrangements along with the interaction and assurance received from NWSSP Procurement Services.	Deputy CEO/Director of Finance Information & IT Services	TBC
Core Financial Systems	15	CRR 001	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	Deputy CEO/Director of Finance Information & IT Services	Q2

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Primary Care – Ophthalmology Contract	16	CRR 008	Review of the processes for managing the ophthalmology contract and monitoring and reporting performance.	Deputy CEO/Director of Finance Information & IT Services	Q3
Information Governance Follow-up	17	CRR 009	Follow-up of 23/24 Limited Assurance report. Will need to agree the timescale for carrying out the follow-up.	Deputy CEO/Director of Finance Information & IT Services	TBC
Records Management	18		Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.	Deputy CEO/Director of Finance Information & IT Services	Q3
Additional Learning Needs Legislation (Deferred from 23/24 plan)	19	CRR 006	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	Director of Therapies and Health Science	Q2/3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medical Devices - Mattresses	20	CRR 003	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.	Director of Therapies and Health Science	Q4
Cleaning Standards	21		Review of processes and controls in place to ensure compliance with national cleaning standards.	Director of Therapies and Health Science	Q1
Site Co-Ordination	22		Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	Director of Therapies and Health Science	Q4
Business Continuity Planning	23		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.	Director of Public Health	TBC
Community Cardiology	24		Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.	Director of Public Health	TBC

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Estates Assurance – Energy Management	25	CRR 010	Increased energy tariffs are acknowledged as a key risk, so there is an increased need to ensure appropriate energy management and control arrangements are applied. Energy Management will be the focus of all UHB/Trust estates assurance reviews across NHS Wales during 2024/25, enabling the production of a national summary report on conclusion.	Director of Capital, Estates & property	TBC
Capital Systems	26	CRR 010	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.	Director of Capital, Estates & property	TBC
Capital Project	27	CRR 010	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.	Director of Capital, Estates & property	TBC

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Estates Condition Follow-up	28	CR010	Potential follow-up audit if the 23/24 audit is finalised as Limited. Will need to agree the timescale for carrying out the follow-up	Director of Capital, Estates & property	TBC
Follow-up – Recommendation Tracking	N/A	N/A	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Director of Corporate Governance	Q4
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A	CRR 010	In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the health board to "assess the risk profile of the scheme and provide appropriate levels of review". A small provision of days is included within the 2024/25 plan to enable us to work with the health board to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.	Director of Capital, Estates & property	See IAAPs

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

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

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

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

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

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

2 Purpose and responsibility

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

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

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

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

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

3 Independence and Objectivity

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

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

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

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

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

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

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

4 Authority and Accountability

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

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

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

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

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

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

5 Relationships

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

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

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

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

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

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

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

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

6 Standards, Ethics, and Performance

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

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

7 Scope

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

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

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

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

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

8 Approach

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

Figure 1: Audit planning hierarchy

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

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

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

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

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

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

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

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

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

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

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

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

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage;

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

- Timely.

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

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's

Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2024

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.4

Audit Risk and Assurance Committee	**Date of Meeting: 11th March 2024**
Subject:	**Counter Fraud Work Plan 2024/25**
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:	Paper being considered at Executive Committee on the 6 March, any feedback will be contributed verbally to the meeting on the 11 March 2024.

PURPOSE:

The Counter Fraud Work Plan 2024/25 is presented to the Audit Risk & Assurance Committee to seek approval. Planned activity is set out around key areas of work intended to be undertaken by the Local Counter Fraud Specialists during 2024/25 and takes account of the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.

RECOMMENDATION(S):

It is recommended that the Audit Risk & Assurance Committee **APPROVE** the Counter Fraud Work Plan 2024/25 as presented.

Ratification	Discussion	Information
X		

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

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				

Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				

Risk Assessment:

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

Counter Fraud Work Plan 2024/25

Matthew Evans
Head of Counter Fraud Services

Introduction

Following introduction of new Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22, the Health Board's Counter Fraud Work Plans have been aimed at ensuring compliance for the first enforcement year of the new standards in 2023/24.

There were two Standards Components that were Amber rated at the start of 2023/24;

- Component 1B - Accountable individual - rated Amber
- Component 3 - Fraud bribery and corruption risk assessment - rated Amber

Work Plan actions were included in the 2023/24 workplan to address this and aimed to uplift to Green rating. Due to loss of significant resource in year due to long term sickness within the Counter Fraud Team slippage in delivery of this objective has occurred with the net effect of arriving at commencement of 2024/25 with Component 3 still rated as Amber. This Work Plan focusses resource into this area to recover and to drive towards Green rating by end of 2024/25.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 1.2 FTE of accredited counter fraud specialist resource supplemented by 0.2 FTE admin support which translate to 308 days deliverable for counter fraud activity.

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 208 and reactive days - 100 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.

A business case has been raised with the Director of Finance to seek additional admin support resource for 2024/25. This aims to bring the admin support resource to 0.6 FTE. If authorised and agreed this additional resource will be allocated proportionally to Inform and Involve and Prevent and Deter activity areas to support focussed delivery in these areas.

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture in line with GovS 013 component 11. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	Throughout the Year
2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	Throughout the Year
3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	Q2 and Q4
4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	Throughout the Year
5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	Throughout the Year
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	As Appropriate
7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	Q2 and Q4

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	Q2
9	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Throughout the Year
10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	Throughout the Year
	TOTAL DAYS ALLOCATED	**55**

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
10	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	As Appropriate
11	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Throughout the Year
12	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2, GovS 013 component 3 and GovS 013 component 5.	Throughout the Year
13	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	Q1
14	Review and update information sharing protocols currently in place. Review and refresh protocols with key partners of Internal Audit and Workforce & Organisational Development	Q4
15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Throughout the Year
16	Record and respond to ad-hoc requests for assistance received.	Throughout the Year
17	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
18	Issue of fraud alerts to all appropriate staff.	As Appropriate
19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Throughout the Year
20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Throughout the Year
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	As Required
22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line with GovS 013 component 10.	Throughout the Year
23	Membership of Local Intelligence Network and attendance at meetings.	As Required
	TOTAL DAYS ALLOCATED	**113**

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
24	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	As Required
25	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	As Required
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	As Required
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	As Required
28	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	As Required
29	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	Q1
30	Explore Memorandum of Understanding between Dyfed Powys Police and the Health Board to cover matters of joint interest when undertaking investigation. This will look to formalise links developed over the preceding years and is being undertaken in liaison with the Hywel Dda University Health Board Counter Fraud Team	Throughout the year
	TOTAL DAYS ALLOCATED	**100**

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
29	Attendance at all Fraud Forum meetings held by CFS Wales.	As Required
30	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	Q4
31	Completion and agreement of the annual report with Director of Finance	Q1
32	Regular meetings/liaison with Director and/or Assistant Director of Finance	Throughout the Year
33	Preparation for and attendance at Audit Committee meetings.	As Required
34	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Q4 and As Required
35	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	As Required
36	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	Throughout the Year
37	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	Throughout the Year
38	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	Q2
	TOTAL DAYS ALLOCATED	**40**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	**INFORM AND INVOLVE**	55
B	**PREVENT AND DETER**	113
C	**HOLD TO ACCOUNT**	100
D	**STRATEGIC GOVERNANCE**	40
	TOTAL	**308**

1 Capital Quarter
Tyndall Street
Cardiff / Caerdydd
CF10 4BZ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru

[by-email]

Reference: 4037A2024

Date issued: 5 February 2024

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
Members of the NHS Technical Accounting Group
Hywel Jones – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2023-24

1 We will shortly commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on how we will undertake your 2023-24 audit.

2 Within this letter, we consider the following:

- the proposed audit timetable for 2023-24;
- a review of the 22-23 audit of accounts;
- an update on audit fees; and
- a look forward to key issues impacting on the 2023-24 accounts and other developments.

The proposed audit timetable for 2023-24

3 We wrote to you in March 2023 setting out our proposed timetable for 2022-23 coupled with our rationale. We set out a proposed timetable which reflected:

- the additional resource required to implement our new audit approach driven by ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020);
- the delays we had experienced in completing the 2021-22 Local Government accounts which in some cases ran well beyond 31 March 2023; and
- the global shortage of audit and finance professionals, which impacted on our ability to recruit and retain qualified staff.

4 Taking the above into account, we proposed the following audit certification deadlines:

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

5 We are grateful for the support of colleagues in all NHS bodies, which enabled all 2022-23 audits except for one Local Health Board (LHB) to be certified by the proposed target date of 31 July 2023.

6 We have now reassessed the position for the 2023-24 audit of accounts. Our position has improved on last year. We have made progress embedding the new audit methodology and are further ahead with our audit of Local Government this year than last. However, we are still contending with recruitment and retention challenges which mean we do not envisage quite being able to meet our original planned audit certification deadline for the 2023-24 audit of accounts of 30 June 2024 (as per above).

7 We are therefore proposing the following revised audit certification deadlines:

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

8 As you can see from the above, our intention is to still try and work to our original timetable for the audit of accounts 2024-25. We believe this is achievable when we take into account it will be our third year delivering audits under our new approach which should generate efficiencies. That said, the achievement of the timetable for 2024-25 is not without its challenges, particularly if market conditions persist in respect of the recruitment and retention of qualified auditors.

9 We recognise that for the forthcoming audit of accounts 2023-24, our deadline is slightly later than many bodies would like but we believe it is important to set realistic timescales given our current position and alert the Service to our proposals as soon as practically possible.

10 We will be working closely with the Welsh Government and NHS finance teams over the next few months to agree the precise timings for submission of draft accounts. There will inevitably be logistical matters to take into account at each body, and we are conscious of the need to factor in Audit Committee, Board and Annual General Meeting (AGM) dates, particularly as Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

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

Review of the 2022-23 audit of accounts

12 Our audits of NHS accounts for the year ended 31 March 2023 were carried out under revised Auditing Standard, ISA 315. In planning our audit at individual Health Bodies, we were required to undertake more detailed and extensive risk assessment procedures to identify the risks of material misstatement and to develop an audit approach designed to address those risks.

13 This revised standard had a significant and far-reaching impact on our audit methodology, and we are grateful to Finance Teams for their engagement and the support they provided to our audit teams.

14 All audits except for one Local Health Board (LHB) were certified by the agreed administrative certification date - 31 July 2023. The delay for the final LHB was as a result of issues arising during the audit. All NHS bodies were certified before the NHS statutory deadline which is four months after submission of the draft accounts (early September 2023).

15 With regards to our audit opinions and reports, none of the NHS Trusts or Strategic Health Authorities received any qualifications. All except one of the LHBs had regularity qualifications for breach of break-even duty. In addition, a number of the LHBs had a substantive report for a failure to meet the second financial duty (lack of an approved financial plan). A summary of our NHS opinions and reports can be seen in **Appendix 1**.

16 2022-23 was a technically challenging year due to the quinquennial valuation of the NHS estate and implementation of the new leasing standard - International Financial Reporting Standard (IFRS) 16. As a result, we identified more

adjusted and unadjusted audit adjustments than in previous years. We also continued to see audit adjustments being required to remuneration report disclosures, along with issues relating to the approval of senior officer remuneration. In many cases, we also identified issues with year-end payables balances which increased audit testing. We will continue to work with individual bodies and make recommendations for improvement.

17 We held a number of meetings with key NHS finance groups during the year and we intend to continue with these meetings going forward. In particular, we welcomed our invitation to meet with the Audit and Risk Committee Chairs as a group and would be keen to do so again this year.

Update on audit fees

18 As a result of ISA 315, the revised audit approach applied in 2022-23 required us to employ more experienced, professionally qualified, staff on the audits, resulting in the larger than usual increase in your audit fee last year. We estimated that fee increase required to support the implementation of this new approach would be around 10.2%. In addition, we also applied a 4.8% fee increase last year in respect of inflation resulting in a combined average fee increase of 15%.

19 On the completion of our 2022-23 audits, we initiated a fee review as part of our post-project learning process. In summary, we concluded that the specific uplift of 10.2% to support the implementation of the revised auditing standard was not quite sufficient across all NHS audits. The total amount of further audit cost overrun incurred on NHS audits amounted to 10.1% which is equivalent to £234,000.

20 Recognising the cost pressures prevalent across NHS Wales, we have decided not to invoice for these overruns where there were no significant issues arising during the audit process. This means that we will be absorbing overspends of over £100,000. Our ability to absorb these overruns has been made possible this year by identifying additional 'one-off' efficiencies internally and should not be seen as creating a precedent for future years.

21 In terms of this year, our Fee Scheme for 2024-25 is now available Fee Scheme 2024-25 | Audit Wales. Our fee rates are increasing on average by 6.4% next year. Some further context is provided in the consultation foreword, but we have incorporated the key message into this letter.

22 Like the rest of the public sector, we are facing significant staff cost pressures. As stated above, those are exacerbated by a global shortage of audit and

finance professionals, which we are seeing reflected in our ability to recruit and retain qualified staff.

23 It is important that we do all that we can to address the recruitment and retention challenges if we are to continue to bring audit deadlines forward in accordance with the revised timetable set out above. To help offset increasing staff costs, we are taking difficult decisions to reduce our non-staff expenditure. We have moved to smaller, cheaper offices in both South and North Wales, have significantly reduced our travel and associated costs, and removed financial allowances previously paid to staff.

24 It is worth pointing out that audit fees have increased significantly across the whole audit profession in response to regulatory pressures, new auditing standards (including, but not limited to, ISA 315) and rising staff costs. The table in **Appendix 2** summarises current Public Sector Audit Appointment (PSAA) rates and then compares them to current Audit Wales fee rates. The table illustrates the very substantial change in PSAA rates over the past four years (following the Redmond Review) and highlights the very marked difference between current local government rates in England and those of Audit Wales. Whilst we are focusing on fee rates within the local government arena, this is indicative of the rising audit costs across the border.

25 Legislation requires that the fees we charge may not exceed the full cost of exercising the function to which the fee relates. We set our audit fees based on our estimated cost base, the estimated skills mix for audit work and the estimated number of days required to complete the work. We do not, and cannot, make a profit from our work. Our fees are set at a level to recover the estimated full cost but no more.

26 We are also mindful of us moving into the second year of our new audit approach and methodology. On the basis that we are more familiar with the new approach, we are expecting to see some level of efficiency. As stated above, as our fees are set at a level to only recover the full cost, where the full cost is less than the estimated fee, we will issue a refund to individual bodies. In this context, we remain determined to minimise audit fees whilst ensuring that our audit quality continues to meet rigorous standards.

27 Your Engagement Director will discuss the proposed fee for your audit once the audit commences and the risk assessment for your organisation has been completed.

A look forward to key issues impacting on the 2023-24 accounts audit and other developments

28 As well as reflecting on last year, it is important to have a look at some of the issues that could impact on the 2023-24 accounts.

29 **Projected year-end deficits** – we are mindful of the control total deficit of £123 million set by Welsh Government across the whole of the NHS and how challenging this will be for NHS bodies to meet. Given these expectations, we will focus on certain areas, particularly accruals and expenditure around year-end.

30 In terms of our wider audit responsibilities, the situation has prompted us to remain focused on themes such as financial sustainability, the realism of savings plans and the continued need for NHS to deliver value for money. Alongside these themes, the Auditor General for Wales places significant importance to seeing high standards of governance and financial management and will continue to shine a light and report on weaknesses in these areas.

31 **Executive salary pay points** – this has been a recurring theme for audit over the past few years where executive salaries have been paid over and above the defined salary point determined by the Welsh Government and where Government approval to do so has not been sought or provided. This again will be an area of focus as part of our audit work on the remuneration report. In addition, a disproportionate amount of time is spent seeking to reconcile payments to contracts of employment for senior staff. This is generally an area where health bodies could seek to improve audit evidence.

32 **Other technical changes** – at this point in time, we are not anticipating any new significant issues, but we will continue to liaise with Health and Social Services Group (HSSG) and the NHS Technical Accounting Group (TAG).

33 **Reintroduction of an interim audit** – for 2022-23, we applied little or no interim audit. This was a deliberate decision due to us commencing NHS audits much later than our normal timings. As we aim to recover and potentially bring the timetable back, we are envisaging moving back to an interim audit this year. This will hopefully take pressure off both Finance and audit teams, particularly during the final audit period scheduled for May and June 2024.

34 **Data quality / Analytics Assisted Audit (AAA)** – since the 2020-21 audit cycle, we have been using general ledger data obtained from the NHS Wales Shared Service Partnership (NWSSP) in our Analytics Assisted Audit application to support our audit work. This has realised several benefits with auditors having more accessible and timely access to the data, enhanced risk

assessments and automation of some audit tests. However, we have identified several inefficient processes and barriers to our vision of a more data driven audit, including:

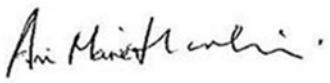
- adjustments cited on working papers not posted through the financial system;
- multiple mapping documents and inconsistent approaches for preparing the individual notes to the accounts; and
- multiple working papers to support individual notes to the accounts.

35 We are initially working with some pilot NHS bodies to try and eradicate these issues with the expectation that it will generate considerable benefits to improving data quality and time saving efficiencies for both audited bodies and auditors. We will engage with the sector on these developments during the early part of 2024.

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

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

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – A summary of NHS audit opinions and reports for 2022-23

Health Board	Qualification/Subs Report
Aneurin Bevan	Qualified Regularity – breach of first financial duty (break-even)
Swansea Bay	Qualified Regularity – breach of first financial duty (break-even)
Powys	Qualified Regularity – breach of first financial duty (break-even)
Cardiff & Vale	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Cwm Taf	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Hywel Dda	Qualified Regularity – breach of first financial duty (break-even) Substantive Report – failure to agree an approved financial plan (second financial duty)
Betsi Cadwaladr	Qualified True and Fair opinion – impact of uncertainty coming forward from 21-22 (expenditure and payables) Qualified Regularity – payment to interim executive director above WG approved pay scale not properly approved. Substantive Report – failure to agree an approved financial plan (second financial duty) Note – first financial duty (break-even) **unqualified**
Velindre	No qualifications
Public Health Wales	No qualifications

Health Board	Qualification/Subs Report
Welsh Ambulance Services NHS Trust	No qualifications
Digital Health and Care Wales	No qualifications
Health Education and Improvement Wales	No qualifications

Appendix 2 – A comparison of current Public Sector Audit Appointment (PSAA) fee rates with Audit Wales

Grade	Audit Wales Fee Rates	Public Sector Audit Appointments (PSAA) Rate Cards	
	2023-24 £	2023-24 £	2018-20 £
Partner / Director	168	414	132
Senior Manager / Manager	129	228	73
Audit Lead	106	148	47
Other	40 - 85	113	36

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1a

Audit, Risk and Assurance Committee	**Date of Meeting: 11 MARCH 2024**
Subject :	**ANNUAL ACCOUNTS 2023/24** **Timetable and Principles for the Financial Methodology and Approach at Year End**
Approved and Presented by:	Deputy CEO / Director of Finance, Information and IT
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an outline of the approach and principles to be adopted for completion of the 2023/24 Annual Accounts together with the planned approach to key financial areas.

RECOMMENDATION(S):

The Audit Committee is asked to:

- **NOTE** the content of this report;
- **NOTE** and take **ASSURANCE** from the planned approach to accounting areas including use of estimates where needed as outlined within the paper including:
    - The timetable, key dates and milestones for the submission of the Annual Accounts for 2023/24;

- the arrangements in place for the review and adoption of the Annual Accounts;
- the approach for accounting for capital issues;
- the approach for accounting for primary care accruals;
- the approach for accounting for retrospective continuing health care claims;
- the anticipated movements in other key provisions;
- the impact of other matters.

Ratification	Discussion	Information
✓		

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

EXECUTIVE SUMMARY:

The Health Board has a statutory duty to complete and submit Annual Audited Accounts to Welsh Government. This paper is to inform the ARA Committee of the work completed to date and the further steps required. Plus, the key methodology to be adopted in completing the Annual Accounts process.

DETAILED BACKGROUND AND ASSESSMENT:

The purpose of this paper is to update the Committee on the plans in place to close the Annual Accounts for the year ending 31 March 2024.

This paper outlines the timetable and key dates for delivery of the Annual Accounts.

This paper also highlights key financial assumptions and methodologies to be adopted and the impact of this on the Annual Accounts.

NEXT STEPS:

- Adherence to the timetable and approach as defined within the paper.

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

1. INTRODUCTION

1.1. The purpose of this paper is to provide the Audit Committee with a briefing on the plans in place to close the Annual Accounts for the year ending 31st March 2024.

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

2. BACKGROUND

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

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

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

Annual Accounts Task	Deadline
Issue NHS Debtor Balance Statements to other NHS Wales bodies	4 April 2024
Sign off date for Agreement of NHS Wales Debtors & Creditors	9 April 2024
Issue Income transactions to NHS Wales bodies	11 April 2024
Sign off date for agreement of NHS Wales Income & Expenditure	17 April 2024
Finalise Health Board Outturn Position	9 April 2024
Close Health Board old year financial ledger	9 April 2024
Submit LMS to Welsh Government	18 April 2024
Preparation of draft Accounts Senior Finance Team review	25 April 2024
Submission of Draft Accounts to Welsh Government	3 May 2024
Submission of Draft Accountability Report and Performance Overview (including Remuneration Report) to Welsh Government	10 May 2024
Submission of Audited Accounts	15 July 2024

2.4. To note these timescales are reduced in comparison to 2022/23 due to the Audit Wales move away from the extended 2022/23 audit timeline that has been communicated to all NHS Wales bodies and details of this is included within the committee papers under the Audit Wales Audit Plan/Update.

3. GOVERNANCE AND RISK ISSUES

3.1. The Audit Committee meeting scheduled for Tuesday 14 May 2024, will receive the draft Annual Accounts, Accountability and Performance Report and the Remuneration Report.

3.2. A special meeting of the Audit Committee will need to be arranged in early to mid July 2024, once the audit resource timetable is provided to the THB by Audit Wales. This will be to review the full audited statements and reports, with a Board meeting to formally adopt them shortly after. The deadline for submission of the approved audited accounts and associated reports to Welsh Government is indicated to be 15th July 2024.

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

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

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

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

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

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

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

A. CAPITAL ISSUES

i. De-recognition

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

ii. IFRS 16

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

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

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

This note will continue to be updated to include new leases taken out and any change to existing leases since 1st April 2023.

B. PRIMARY CARE ACCRUALS

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

The Health Board has reviewed the accounting methodologies used across the primary care accrual areas last year. This review has taken into consideration actual outturn values against accrual values and whether there have been any amendments to primary care contracts in year to determine whether any changes are required for 2023/24. The outcome of this work has concluded the following:

i. GMS Enhanced Services

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

Following a more complicated process for 2021/22 in which payments were based against a 2019/20 baseline, and a % threshold to deliver against, the process in 2022/23 returned to an accrual based on predicted actual achievement, and this will continue in 2023-24. The accrual will be based on best estimates and information available at M12 and clearly identified in a working paper.

ii. GMS QIF (Quality and Improvement Framework)

Under the QIF scheme, GP Practices achieve a certain level of points and these are multiplied by £x value per point (varies depending on practice weighted list size) to establish the payments due. QAIF years ran from 1 October to 30 September, so the final achievement value for M7-12 of a given year was not known until the following December. Estimates were, therefore, required to drive the year end accrual. However, for 2023-24 there has been no change mid-year so this makes the estimation more straightforward.

Points to note for this year's formula:

- For 2023-24 the points available have remained as QA/QI – 170, Access – 100, Total 270.

iii. Pharmacy Contract

No changes are proposed for the approach to calculating the accruals from 2022/23. Estimates will predominantly be an adjusted straight line, which includes any adjustments for additional identified costs as part of the year-end review.

iv. Primary Care Prescribing

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

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

The continued trends, month on month in 2023/24 (0.99% average increase from April to December) has required the Health Board to add trend forecasting to the analyses identified above when calculating a position to forecast.

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

C. RETROSPECTIVE CONTINUING HEALTH CARE CLAIMS (OMBUDSMAN PROVISION)

i. Background

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

During 2014, the Welsh Government launched an advertising campaign to draw the public's attention to the cut-off date for retrospective continuing NHS health care claims

relating to the period 1st April 2003 to 31st July 2013 (Phase 3). Claimants needed to register their intent to claim by 31st July 2014, and no later than 31st December 2014 (later extended by Welsh Government to 31st January 2015), to provide evidence of their right to make the claim and proof of fees paid to the care home or domiciliary agency. The intent to claim and the supporting documentation had to be submitted to the All Wales Retrospective Review Team within Powys HB.

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

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

Further annual publicity campaigns have resulted in the ability to claim for periods post July 2013. For phase 4 and subsequent phases, the average success rate will be continued to be used to make a reliable estimate for probable claims based on the average weekly rate. All phase 4,5 & 6 cases have now been settled. As at 31st March 2024 a provision will be provided for the phase 7 claims, currently recording 9 cases.

D. REPORTING ISSUES

i) Pension 6.3%

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

A transitional approach was agreed with the Business Services Authority, whereby an employer rate of 20.68% will apply from 1 April 2019, however, in 2019-20 the Business Services Authority will only collect 14.38% from NHS Wales bodies. Central payments have been made by Welsh Government for the outstanding 6.3% on behalf of NHS Wales bodies. This continues in 2023/24.

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

ii) Scheme Pays

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

For the 2019/20 accounts no disclosure with regard to this policy was provided as the information to determine whether a provision or contingent liability was required was not available. For the 2020/21 accounts a narrative contingent liability note was disclosed detailing the scheme as insufficient information was available to support a

provision. For the 2021/22 accounts a provision was required for the future costs of this commitment by NHS bodies. Welsh Government is working with the NHS Pensions Agency and Government Actuaries Department to identify the estimated costs for each health body and there will be a requirement for each health body to disclose a provision in the 2023/24 accounts. There will not be an impact to the financial performance of the health board as Welsh Government has advised that, as in 2022/23, the provision will be offset within the financial statement by a debtor to Welsh Government. This is similar to the process for the Welsh Risk Pool.

In 2021/22, the provision included within health board accounts for the cost of Scheme Pays was considered to constitute an irregular expenditure and led to a qualification of the health board's accounts in respect of the regularity opinion. In 2022/23, there was no effect on the audit opinion for balances held. We understand that the Auditor General for Wales will be considering what may be required in respect of this this year.

E. MOVEMENT IN OTHER KEY PROVISIONS

I. Early Retirement Pension Provision / Permanent Injury

There has been a further change in the Discount Factors to be applied in line with the draft Manual for Accounts issued by Welsh Government in December 2023. This directs health boards to use 2.45% this year (1.70% 2022/23). Together with a recent change in life expectancy will result in a financial cost reduction of £0.035M this year.

PTHB also account for the permanent injury provision in respect of a former member of staff of Health Authorities which were reorganised into Health Boards in April 2003. This provision although not material within the THB accounts is fully funded by Welsh Government and therefore any financial impact on movement of this provision year on year is reimbursed to the Health Board via an allocation by Welsh Government so has no impact on the reported performance of the Teaching Health Board.

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

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

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

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

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

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

In 2022/23 the Health Board provided on the basis outlined in the table above with the percentages used to provide for probability 3 cases being 28% for Clinical Negligence cases and 56% for Personal Injury cases. This percentage will be used again for 2023/24. Based on the 3rd quarter quantum reports from Welsh Health Legal Services this has resulted in a increase in the provision of £0.258M This figure may be subject to change as more recent quantum is received.

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

III. Accounting for Redress Provisions

At the end of the 2018/19 financial year responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool. At the same time, Welsh Risk Pool changed the accounting requirement for redress cases from a cash basis to an accruals basis therefore requiring provisions to be included in the 2018/19 accounts for redress cases for the first time. This accounting treatment is again in place for 2023/24 with provisions for redress cases being included in the accounts based on estimated claim costs provided locally by the Concerns Team. Therefore, as at month 10 a provision of £0.075M is anticipated for this scheme in the 2023/24 year-end accounts. This amount may be subject to change based on the receipt of March 2024 quantum's but is not expected to be significant. As all payments made in respect of redress cases except for the claimant's legal costs (capped at £1,920) are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

IV. GP Indemnity Scheme

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GPs and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. To date the health board has received five claims under this scheme with four remaining ongoing. Therefore, as at month 10 a provision of £0.027M is anticipated for this scheme in the 2023/24 year-end accounts. This amount may be subject to change based on the receipt of March 2024 quantum's but is not expected to be significant. As all payments made in respect of such cases are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

F. Other Matters

i) Annual Leave

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

The Executive Team communicated in 2022/23 to the organisation that it was now reverting back to its policy and for all staff to utilise annual leave in full and so it is not anticipated that an annual leave accrual will be included within the Annual Accounts

ii) Continuing Health Care

The THB has released from its Statement of Financial Position in respect of two individual Continuing Health Care cases a provision with a value of £2.473M (including estimated legal fees) regarding claims from Powys County Council (PCC) that the Health Board is responsible for care provision fees in respect of the individual patients. These claims were being managed by NWSSP Legal and Risk and a settlement of the claims has taken place during 2023/24 with the remaining amount of the provision released into the reported financial position of the Health Board for 2023/24.

There are further cases between PCC and the THB under consideration. These may result in expenditure needing to be recognised in the 2023/24 accounts. The Finance team will keep appraised of this developing situation and ensure that it is accounted for in line with IFRS accounting standards.

4. REMOTE WORKING

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

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

5. TRANSFER OF COMMUNITY HEALTH COUNCIL FUNCTION TO LLAIS

On the 1st April 2023 the previous hosted function of Community Health Councils has been transferred into the newly created organisation LLAIS. As part of these arrangements Assets and Liabilities held at the 31st March 2023 relating to the Community Health Councils have been transferred via an agreed S1 and S2 Welsh Government Transfer process to LLAIS. This process and amounts may be subject to audit as part of the annual accounts work and numerous notes and disclosures will reference the transfer arrangements.

6. RECOMMENDATIONS

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

a) The timetable, key dates and milestones for the submission of the Annual Accounts for 2023/24;
b) the arrangements in place for the review and adoption of the Annual Accounts;
c) the approach for accounting for capital issues;
d) the approach for accounting for primary care accruals;
e) the approach for accounting for retrospective continuing health care claims;
f) the anticipated movements in other key provisions;
g) the impact of other matters.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.2

Audit, Risk and Assurance Committee	**Date of Meeting: 11th March 2024**
Subject:	**Internal Audit Progress Report**
Approved and Presented by	Director of Corporate Governance / Head of Internal Audit
Prepared by:	Head of Internal Audit
Other Committees and Meetings considered at:	

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Note** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.

- **Approve** the proposed adjustment to the 2023/24 plan.

Approval	Discussion	Information
X		X

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

EXECUTIVE SUMMARY:

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

The following audit reports have been finalised since the January 24 meeting of the Committee:

- Primary Care Dental Services – Management and Monitoring of GDS Contract (Substantial Assurance)
- Board & Committee Structure / Effectiveness (Substantial Assurance)
- Follow-up: IT Infrastructure and Asset Management (Reasonable Assurance)
- Follow-up: Cyber Security (Reasonable Assurance)
- Estates Assurance (Limited Assurance)

The full copies of the final reports are included as separate items within the agenda.

The progress report also includes details of a proposed adjustment to the content of the 2023/24 plan.

Progress with the delivery of the 2023/24 plan is also detailed within Appendix A of the progress report.

BACKGROUND AND ASSESSMENT:

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

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

The 2023/24 plan was formally approved by the Audit, Risk and Assurance Committee at its March 23 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 proposed adjustments to the plan.

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

NEXT STEPS:

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

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
March 2024

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2023/24 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 2023/24 was agreed by the Audit, Risk & Assurance Committee in March 2023 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

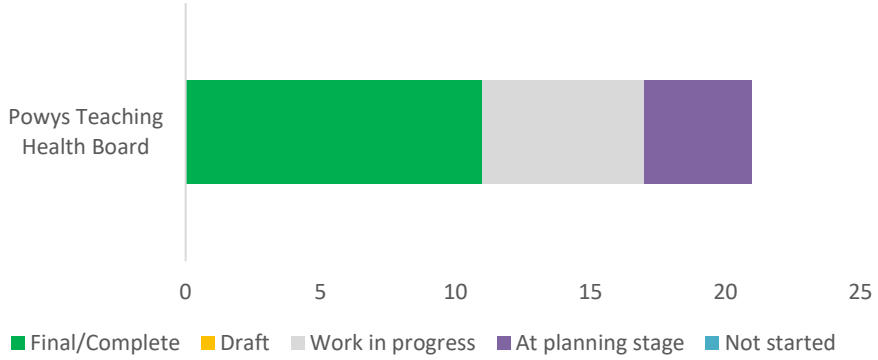
Five assignments from the 2023/24 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance rating.

The full versions of the reports are included on the committee's agenda as separate items.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Primary Care Dental Services – Management and Monitoring of GDS Contract	Substantial	
Board & Committee Structure / Effectiveness		
Follow-up: IT Infrastructure and Asset Management	Reasonable	
Follow-up: Cyber Security		
Estates Condition	Limited	

3. Delivery of the 2023/24 Internal Audit Plan

There are a total of 21 reviews included within the 2023/24 Internal Audit Plan (including the change detailed under section 4 below), and overall progress is summarised below.



The graph above illustrates that eleven audits have been finalised so far this year.

In addition, there are six audits that are currently work in progress with the remaining Four at the planning stage.

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

Appendix A also includes details of one audit from the 2022/23 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2022/23. The outcome from that audit will feed into the 2023/24 Opinion.

4. Changes to the 2023/24 Plan

- **Additional Learning Needs Legislation**

  Proposed that this audit is deferred from the 23/24 plan and considered as part of the planning for 24/25. Due to service pressures and ongoing planned developments and actions around ALN.

  This has been agreed with the Director of Therapies & Health Sciences.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2022/23 Plan								
SLAs for In Reach Medical Staff	Actions taken to review and update SLA arrangements for in-reach medical staff across all Health Board services.		Medical / Performance and Commissioning			Final	Reasonable	October
2023/24 Plan								
Clinical Audit	To review the adequacy of the systems and controls in place for the planning, delivery and reporting of Clinical Audit work.	12	Medical	1		Final	Reasonable	October
Information Governance	To evaluate and determine the adequacy of the resourcing, capacity, and resilience of the Information Governance structures to achieve compliance with GDPR and FoI requirements.	09	Deputy CEO/Finance Information & IT Services	1		Final	Limited	January
Clinical Education - HCSW Induction Programme	Review the arrangements for the deployment of the Framework, including the induction programme to establish if effective processes are in place to ensure compliance.	04	Workforce & Organisational Development	2		Final	Reasonable	January
Health & Safety Arrangements	Review and assess the adequacy of the structures, governance arrangements, policies and processes in place to ensure compliance with Health & Safety legislation.	23	Therapies and Health Science	3		Final	Reasonable	January
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Scope to include IT technical continuity and fault domain awareness within the organisation.	22	Public Health	3/4		Final	Substantial	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Incident Management	Focused review of processes for management of incidents and ensuring effective learning from events. To be undertaken within Maternity and Mental Health Services.	05	Nursing & Midwifery	3		Final	Reasonable	January
Follow-up: IT Infrastructure and Asset Management	Follow-up of 22/23 Limited Assurance report.	11	Deputy CEO/Finance Information & IT Services	3		Final	Reasonable	March
Estates Assurance – Estates Condition	*To determine the adequacy of, and operational compliance with, the health board's systems and procedures, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.*	*24*	*Capital, Estates & Property*	*Q2*		*Final*	*Limited*	*March*
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.	02	Corporate Governance	2/3		Final	Substantial	March
Primary Care Dental Services – Management and Monitoring of GDS Contract	Executive identified Dental Services as one of the key areas for review within Primary Care – Relating to access for patients.	18	Deputy CEO/ Finance Information & IT Services	2/3		Final	Substantial	March
Follow up: Cyber Security	Follow-up of 22/23 Limited Assurance report.	12	Deputy CEO/Finance Information & IT Services	4		Final	Reasonable	March
Continuing Healthcare	Review the processes in place for the assessment, approval, recording and monitoring of CHC to ensure that care is provided to the required standards with appropriate financial controls in operation. Review to include the arrangements covering Child, Adult and Mental Health.	17	Operations / Community & Mental Health	2/3		Work in Progress		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Agency Spend Reduction Project	To review the set-up, operation and delivery of the Agency Spend Reduction Project.	08	Operations / Community & Mental Health	3/4		Work in Progress		May
Infection Prevention and Control	Review of the structures, plans, monitoring and reporting arrangements in place across the Health Board (including Primary Care and Care Homes) to ensure that the risk of infection is minimised, and the spread of infection is effectively controlled, and all relevant guidelines and legislation are complied with.	06	Nursing & Midwifery	4		Work in Progress		May
Welsh Language Standards Follow-up	Follow-up of 22/23 Limited Assurance report.	16	Workforce & OD	4		Work in Progress		May
Vaccination Programmes	Review the development of structures and plans for the on-going delivery of vaccination programmes.	21	Public Health	4		Work in Progress		May
End of Life Care Services	A review of Frailty and / or Endo of Life Care Services to be included for the second half of the plan. Exact scope of the review will need to be considered and agreed.	13	Medical	3/4		Planning, final brief issued		May
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. Scope to include how the Health Board are managing quality from visiting clinicians and the interface with EASC / WHSSC.	19	Performance & Commissioning	3/4		Planning, final brief issued		May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance	4		Planning, final brief issued		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Patient Experience	Review of the arrangements and processes in place around patient experience, potentially focusing on quadrant reporting. Further discussion needed to determine and agree exact scope.	14	Nursing & Midwifery	4		Planning, final brief issued		May
Decarbonisation	To consider progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Health Board's Decarbonisation Action Plan (demonstrating how they will implement the Strategic Delivery Plan initiatives). Following on from the advisory review delivered in 2022/23.	24	Capital, Estates & Property	4		Work in Progress		May
Reviews removed from the plan								
Staff Recruitment & Retention – New scope for audit to be agreed	Review and assessment of the plans and processes in place to enable the Health Board to recruit and retain an appropriate workforce to allow the sustained delivery of high-quality services.	03	Workforce & Organisational Development	Proposed that this audit be removed from the plan due to focus on reducing staff costs as part of current savings plans. To be replaced by audit of Decarbonisation. Agreed with Director of Workforce & OD. Approved by January 24 ARAC.				
Efficiency Framework / Value Board.	Provide assurance around the development, monitoring and achievement of the Health Board's financial plans linked to efficiency and sustainability.	07	Deputy CEO/ Finance Information & IT Services	Proposed that this audit be removed from the plan due to Audit Wales focus on financial savings as part of their Structured Assessment. Agreed with Director of Finance, Information & IT. Approved by January 24 ARAC.				
Partnership Governance Framework.	Review of the development and implementation of the Framework.	20	Performance & Commissioning / Corporate Governance	Proposed that this audit is deferred from the 23/24 plan and considered as part of the planning for 24/25. The development of the Framework has not progressed as planned. Agreed with Director of Corporate Governance / Director of Performance & Commissioning. Approved by January 24 ARAC.				
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).	15	Therapies and Health Science	Proposed that this audit is deferred from the 23/24 plan and considered as part of the planning for 24/25. Due to service pressures and ongoing planned actions around ALN. Agreed with Director of Therapies & Health Sciences. To be approved by March 24 ARAC.				

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
SLAs for In-Reach Medical Staff	Reasonable	Final	02/08/23	24/08/23	24/08/23	24/08/23	G
Clinical Audit	Reasonable	Final	11/09/23	02/10/23	26/09/23	26/09/23	G
Information Governance	Limited	Final	14/09/23	05/10/23	07/11/23	07/11/23	R
Clinical Education - HCSW Induction Programme	Reasonable	Final	30/10/23	20/11/23	31/10/23	02/11/23	G
Health & Safety Arrangements	Reasonable	Final	30/11/23	21/12/23	13/12/23	14/12/23	G
Business Continuity Planning	Substantial	Final	08/12/23	03/01/24	21/12/23	22/12/23	G
Incident Management	Reasonable	Final	15/12/23	10/01/24	29/12/23	03/01/24	G
Follow-up: IT Infrastructure and Asset Management	Reasonable	Final	21/12/23	16/01/24	08/02/24	12/02/24	R
Primary Care Dental Services – Management and Monitoring of GDS Contract	Substantial	Final	23/01/24	13/02/24	13/02/24	21/02/24	G
Follow-up: Cyber Security	Reasonable	Final	19/02/24	11/03/24	19/02/24	26/02/24	G
Board & Committee Structure / Effectiveness	Substantial	Final	20/02/24	06/03/24	01/03/24	01/03/24	G
Estates Condition	Limited	Final	25/01/24	14/02/24	04/03/24	04/03/24	R

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	March 2023	By 30 June	Not agreed	Draft plan	Final plan
Audits reported versus total planned audits, and in line with Audit Committee expectations.	A	80% 12 from 15	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	92% 11 from 12	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 9 from 12	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 12 from 12	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

Office details:

Audit and Assurance Services
1st Floor, Woodland House
Maes y Coed Road
Cardiff
CF14 4HH.

Contact details
Ian Virgill (Head of Internal Audit) - ian.virgil@wales.nhs.uk

Primary Care Dental Services – Management and Monitoring of General Dental Services (GDS) Contract

Final Internal Audit Report

February 2024

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB-2324-18
Report status:	Final
Fieldwork commencement:	16th November 2023
Fieldwork completion:	9th January 2024
Draft report issued:	23rd January 2024
Management response received:	13th February 2024
Final report issued:	21st February 2024
Auditors:	Stuart Bodman, Principal Auditor Jayne Gibbon, Audit Manager Ian Virgill, Head of Internal Audit
Executive sign-off:	Peter Hopgood, Interim Deputy Chief Executive, and Director of Finance, Information & IT Services
Distribution:	Jayne Lawrence, Assistant Director of Primary Care Services Warren Tolley, Dental Director
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.

Executive Summary

Purpose

The overall objective of the audit was to review the controls and processes in place for the for the management and monitoring of the GDS Contract.

Overview

We have issued substantial assurance on this area. Noting the following key processes that are in place:

- Performance reviews were undertaken with all contractors for 2022/23;
- There is a forum in place that meets regularly to provide monitoring of patient demand, capacity and access; and
- Updates on contract delivery is reported on a regular basis as part of the organisational Integrated Performance Report at appropriate Board meetings.

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. We acknowledge that the Health Board is dealing with a significant risk around access to dental services for Powys residents and this is clearly documented within its Corporate Risk Register. Whilst the underlying risk remains, we are able to provide assurance that the processes operating within the Health Board are providing effective review, monitoring, reporting and escalation.

We identified one key matter for reporting in our review relating to the quoracy of the GDS Monitoring Group that impacted on meetings taking place.

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

Report Opinion

Substantial assurance

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

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	Annual performance reviews against the requirements within the GDS Contract are undertaken with dental contractors	Substantial
2	Regular monitoring is undertaken of patient demand and the levels of capacity and access to dental contractors.	Reasonable
3	The Health Board receives assurance in respect of the GDS contract performance and patient access.	Substantial

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

Key Matter Arising

		Objective	Control Design or Operation	Recommendation Priority
1	GDS Monitoring Group Quoracy	2	Operation	Medium

1. Introduction

1.1 Our review of Primary Care Dental Services – Management and Monitoring of the General Dental Services (GDS) Contract was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 require that the GDS Contract is appropriately operated and monitored for patient access, and this is covered by Regulation 39 which requires the Health Board to hold formal performance review meetings with each contractor on an annual basis and produce a final written record.

1.3 We acknowledge that the Health Board faces several challenges in the delivery of dental services including the recruitment and retention of dentists, sparse population and rurality.

1.4 The Health Board's Corporate Risk Register includes a risk that 'The demand and capacity pressures in the primary care system led to services becoming unstable.' An element of the rational for the risk relates to 'Dental access gaps across Powys with demand for access currently greater than capacity.'

1.5 The Interim Deputy Chief Executive Officer/Executive Director of Finance, Information and IT Services is the Executive Lead for the review.

1.6 The potential risks considered during this audit are as follows:

- Non-compliance with the requirements of the NHS GDS contract resulting in potential patient harm, reputational damage, and financial penalties.
- Powys residents are unable to access NHS dental services.
- The Health Board is unaware of issues concerning the GDS contract.

2. Detailed Audit Findings

Objective 1: Annual performance reviews against the requirements within the GDS Contract are undertaken with dental contractors and are formally recorded, and outcomes reviewed by the Health Board.

2.1 Annual GDS performance review meetings are held with each dental contractor once all contract activity for the financial year has been completed and submitted to the Primary Care Dental Team. The audit confirmed that annual performance reviews for 2022/23 had been undertaken for 17 of the 18 contractors currently in place. For the one contractor their contract did not commence until 1st May 2023.

2.2 Mid-year performance reviews may also be undertaken where contractor performance is deemed at risk of falling behind, and for those contractors whose performance is known to be falling behind prescribed activity levels. Our testing identified that during 2023/24 no mid-year reviews were required.

2.3 For 2023/24 an additional mid-year review was held in October 2023 with all GDS contractors to discuss performance progress further to the implementation of

additional Welsh Government GDS Contract Reform Guidance issued in December 2022.

Conclusion:

2.4 Annual and interim performance reviews are undertaken against the requirements within the GDS Contract with dental contractors and are formally recorded. We have provided **Substantial Assurance** for this objective.

Objective 2: Regular monitoring is undertaken of patient demand and the levels of capacity and access to dental contractors.

2.5 The Primary Care Division has a GDS Monitoring Group in place which co-ordinates and oversees the management and oversight of general NHS Dental services across Powys. Part of its mandate includes the monitoring of patient demand, capacity, and access to GDS dental contractors.

2.6 All GDS Monitoring Group meetings are supported by a formal Agenda and detailed Minutes which include progress action plans which are followed up in the subsequent meetings.

2.7 Our review of GDS Monitoring Group meeting minutes confirm that there is regular oversight and monitoring of the following:

- Patient Experience and Access to GDS provision.
- GDS Quality & Safety Issues.
- GDS Contractor Financial management.
- GDS Contractor Governance.
- GDS Contractor Concerns.
- GDS Contractor Performance Compliance.

2.8 Risks relating to GDS provision are recorded within the Primary Care Dental risk register which are monitored at each monthly GDS Quality & Safety meeting, and their progress/actions undertaken are documented within meeting minutes.

2.9 Weekly monitoring of demand and access to GDS provision is undertaken and formally documented by the Primary Care General Dental Contracts Team via a comprehensive spreadsheet that records and monitors current demand levels and accessibility to GDS providers. This also includes a waiting list of Powys residents who have yet to be allocated to a GDS dental practice. At the time of our audit there were around 5,000 Powys residents on the waiting list.

2.10 Our review of the GDS Monitoring Group meetings that should have taken place in 2023/24 found that several GDS Monitoring Group meetings were cancelled as they could not achieve quoracy levels. **(Matter Arising 1)**

Conclusion:

2.11 Whilst a substantial number of Powys residents remain on the waiting list for dental services, there is a forum that provides regular and comprehensive monitoring and oversight of patient demand, capacity, and access to GDS provision. Further work is however required to ensure continuance of meetings when quoracy cannot be achieved. We have provided **Reasonable Assurance** for this objective.

Objective 3: The Health Board receives assurance in respect of the GDS contract performance and patient access.

2.12 GDS patient access and contractor performance is discussed and monitored by the GDS Monitoring Group. This information is then included in the organisation's Integrated Performance Report that is submitted to each meeting of the Delivery & Performance Committee as well as the main Health Board meetings. The report provides details of the key NHS Performance Measure 11 that relates to 'Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients'.

2.13 In accordance with the Delivery & Performance Committee's Workplan for 2023/24 the annual GDS contractor performance for 2022/23 year end summary report was submitted for consideration at the Delivery and Performance Committee meeting held in December 2023.

2.14 Currently, the GDS Monitoring Group Terms of Reference (ToR), and the Primary Care GDS Commissioning Assurance Framework do not accurately outline the new reporting arrangements arising from organisational changes made in respect of Health Board Committees. **(Matter Arising 2)**

Conclusion:

2.15 The Delivery and Performance Committee and Health Board meetings regularly receive information relating to patient accessibility to GDS provision and GDS contractor performance, but updating of key governance documentation is required to accurately reflect the current reporting arrangements that are in operation. We have provided **Substantial Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Non-quoracy of GDS Monitoring Group meetings (Operation)			**Impact**
Our review of the GDS Monitoring Group meetings that took place between April and October 2023, noted that two of the seven meetings (May, June, and August) were cancelled as they could not achieve quoracy. However, we note that the other four monthly meetings held were well attended by the Group membership.			The Health Board is unaware of issues concerning the GDS contract.
Recommendations			**Priority**
1	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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	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.	31/03/24	Jayne Lawrence, Assistant Director of Primary Care

Matter Arising 2: GDS Monitoring Group and GDS Commissioning Framework: Updating of reporting and escalation process (Design)	**Impact**
Reporting and escalation lines for GDS contract performance issues as stated in the GDS Monitoring Group Terms of Reference (ToR), and Primary Care GDS Commissioning Assurance Framework are outdated, and do not reflect the actual Health Board/Committee reporting arrangements currently in place. The GDS Monitoring Group ToR is dated 2018, shows no evidence of version control, and has not been revised to reflect that the Health Board Committee structure has changed since its inception. Namely, the Performance and Review Committee, and the Finance, Planning and Performance Committee, which are no longer in operation. Additionally, these legacy Committees are also stated as being operational within the July 2023 iteration of the Primary Care GDC Commissioning Assurance Framework document.	The Health Board is unaware of issues concerning the GDS contract.

Recommendations		**Priority**
2	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.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	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	31/03/24	Jayne Lawrence, Assistant Director of Primary Care

	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.	31/03/24	Jayne Lawrence, Assistant Director of Primary 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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Board & Committee Structure/Effectiveness

Final Internal Audit Report

March 2024

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB-2324-02
Report status:	Final
Fieldwork commencement:	19th December 2023
Fieldwork completion:	14th February 2024
Debrief meeting:	n/a
Draft report issued:	20th February 2024
Management response received:	1st March 2024
Final report issued:	1st March 2024
Auditors:	Jayne Gibbon, Audit Manager Stuart Bodman, Principal Auditor
Executive sign-off:	Helen Bushell, Director of Corporate Governance/Board Secretary
Distribution:	Liz Patterson, Corporate Governance 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.

Executive Summary

Purpose

The overall objective of the audit was to evaluate the Health Board's Board and Committee structure and assess their operation to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.

Overview

We have issued substantial assurance on this area. Noting the following key processes that are in place:

- The Board and its Committees are supported by formally defined governance and assurance arrangements.
- Committee structures in place enables the delivery of efficient and effective scrutiny and decision making.
- Board and Committee Annual Work Programmes align to and facilitate delivery of the organisation's strategic objectives and monitoring of its key risks.
- Business activity is of good quality, clearly and effectively reported between Committees and the Board, and where appropriate issued in the public domain.

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

Report Opinion

Substantial

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

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	The Health Board has clear, defined Board and Committee governance and assurance structures.	Substantial
2	The Committee structure provides for clear, effective, and efficient decision-making and scrutiny on areas of accountability.	Substantial
3	Board and Committee Work Programmes are aligned to the Health Board's strategic objectives and risks.	Substantial
4	Board and Committee reporting is clear and concise and provides effective triangulation of business activity.	Substantial

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

1. Introduction

1.1 Our review of Board & Committee Structure / Effectiveness was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The overall objective of this audit was to 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.

1.3 The current committee structure of the Health Board has been in place since August 2021 with the following committees currently in operation:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Delivery and Performance Committee
- Executive Committee
- Patient, Experience, Quality & Safety Committee
- Planning, Partnerships and Population Health Committee
- Remuneration and Terms of Service Committee
- Workforce and Culture Committee

1.4 Our review focussed its testing on the operation of the following three sampled Committees:

- Delivery and Performance Committee (D&P)
- Executive Committee
- Patient, Experience, Quality & Safety Committee (PEQS)

1.5 The potential risks considered during this audit are as follows:

- Failure to achieve strategic objectives.
- Failure to manage risk
- Financial or reputational damage.

1.6 The Executive lead for this review is the Director of Corporate Governance / Board Secretary.

2. Detailed Audit Findings

Objective 1: The Health Board has clear, defined Board and Committee governance and assurance structures.

2.1 The Board and each Health Board Committee has been established in accordance with the stated requirements of the organisational Standing Orders.

2.2 Each Health Board Committees' Terms of Reference (ToR) clearly defines its roles and responsibilities, and there are no overlaps or conflicts within their respective subject areas of accountability.

2.3 All Health Board Committee ToR documents also outline its constituent membership, quoracy, meeting frequency and reporting arrangements.

2.4 Induction processes for new Independent Members are outlined within a Board Member Library held on the Health Board intranet site, and this also acts as a repository that includes comprehensive and regularly updated resources for training and development.

2.5 However, at the time of our fieldwork, the Health Board Standing Orders (including the Board and respective Committee ToRs) within the public domain were out of date, but we acknowledge that these are to be updated after the May 2024 Board meeting. **(Matter Arising 1)**

Conclusion:

2.6 The Health Board has established and implemented clearly defined governance and assurance structures, but the organisation should ensure that information relating to these within the public domain is current. We have provided **Substantial Assurance** for this objective.

Objective 2: The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.

2.7 Our attendance at each of the three sampled Committees confirmed that committee Chairs efficiently manage the delivery of Agenda items, and effectively engage with Committee members and attendees.

2.8 Our discussions with the three Committee Chairs corroborated and reinforced their approaches in respect of the oversight and scrutiny undertaken within the respective Committee meetings we attended.

2.9 Declarations of Interests for all three sampled Committees are discussed as a Standing Agenda item at each meeting.

2.10 All three Chairs expressed satisfaction with the managerial and Committee secretariat support, and with the ongoing training and development provided by the Health Board.

2.11 Decisions made within these Committees are clearly recorded within their meeting Minutes and are supported by action logs which are subject to ongoing review.

Conclusion:

2.12 Committee structures and the support provided to Committee Chairs by the Health Board allows the effective and efficient delivery and recording of business decision making and outcomes. We have provided **Substantial Assurance** for this objective.

Objective 3: Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks.

2.13 The content of all three sampled annual Committee Work Programmes for 2023/2024 reflects their respective, prescribed Committee ToR risks and objectives.

2.14 Our review of the sampled PEQS and Executives Committee meetings confirms that the items stated on their annual Work Programme were met, and where changes were made these were recorded therein accordingly.

2.15 However, the Delivery and Performance Committee Work Programme was not updated to reflect a small number of necessary changes to timetabled items, and the reasons for these changes were not recorded within the relevant Committee Minutes. **(Matter Arising 2)**

Conclusion:

2.16 We acknowledge that Committee Work Programme items are subject to change, and these changes are largely recorded as a matter of record, however the application of this process is not consistent. We have provided **Substantial Assurance** for this objective.

Objective 4: Board and Committee reporting is clear and concise and provides effective triangulation of business activity

2.17 All sampled Committee Agendas, Minutes and covering papers were issued to Committee members and the public (where appropriate) via the Health Board internet site within a reasonable timescale in advance of the meetings being held.

2.18 Our review of all sampled Committee meeting cover papers and accompanying reports confirm that they are of good quality, detailed and thorough in content.

2.19 All sampled Committee Minutes form the basis of their respective Chair's Reports that are submitted to the next Board meeting, and the content reflects the key decision making and outcomes arising from the discussed Agenda items.

Conclusion:

2.20 Internal and external reporting of Board and Committee activities and outcomes is efficient, clear, and of good quality. We have provided **Substantial Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Online publication of outdated Health Board Standing Orders (Operation)			**Impact**
Our review of the Health Board internet site identified that the Health Board Standing Orders (including the Board and Committee ToRs Schedule 4) that are currently in the public domain are dated 2020 and/or 2021. However, subsequent to our inspection we were advised, and have confirmed, that the Health Board internet site has been updated to include the latest iteration of the Standing Orders dated May 2023, and that the latest version of all Committee ToRs are to be ratified by the May 2024 Board meeting before being published online.			Failure to achieve strategic objectives. Failure to manage risk.
Recommendations			**Priority**
1.1	Management should ensure that the May 2024 Board meeting reviews and ratifies the Health Board Standing Orders, to include the revised and updated iterations of all Health Board Committee Terms of Reference documents. The updated documents should then be published on the Health Board's internet site.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	**Recommendation accepted.** The revised Standing orders and supporting terms of reference and other documents will be presented to the May 2024 Board meeting and then published to the website.	30 May 2024	**Director of Corporate Governance**

Matter Arising 2: Annual Delivery and Performance Committee Work Programme (Operation)	**Impact**
Our review of the two sampled Delivery and Performance Committee meetings held on 17th October and 19th December 2023 confirmed that business items stated on its 2023/24 Work Programme were largely met, and the deviation from stated items (one item 17th October 2023 and two items 19th December 2023) were necessary and justifiable. However, the meeting Minutes or the Committee Work Programme did not state the reasons for the removal of these items from the respective meeting Agendas, nor did they state as to whether they would be deferred to a future meeting.	Failure to achieve strategic objectives. Failure to manage risk.

Recommendations		**Priority**
2.1	The Annual Work Programme should be subject to update and revision to ensure that items of business are accurately timetabled and allocated to Committee meetings. Where timetabled items stated on the Work Programme are subject to change and removed from the respective Committee Agenda, this should be noted within the Minutes stating the reason, and if known, the date of the next Committee meeting to which the item has been rescheduled.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	**Recommendation accepted and completed.** A revised approach has been implemented since the report, changes to work programmes are recorded on the work programme report to the Committee and the report then noted in the minutes.	N/A as complete	**Director of Corporate Governance**

Mills,Belinda
11/03/2024 17:12:59

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Follow-up: IT Infrastructure and Asset Management

Final Internal Audit Report

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB 2324 - 10
Report status:	Final
Fieldwork commencement:	17th October 2023
Fieldwork completion:	15th December 2023
Draft report issued:	21st December 2023
Debrief meeting:	
Management response received:	8th February 2024
Final report issued:	12th February 2024
Auditors:	Kevin Bridgman IT Audit Manager Martyn Lewis, IT Audit Manager
Executive sign-off:	Pete Hopgood, Executive Director of Finance, Information & IT
Distribution:	Vicki Cooper, CDO & Assistant Director Digital Transformation David Owen, Chief Technology Officer
Committee:	Audit and Risk 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.

Executive Summary

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Limited Assurance IT Infrastructure and Asset Management (PTHB2223-09) review. That was reported as part of our 2022/23 work programme.

Overview of findings

We have provided reasonable assurance over this area.

There has been progress in a number of areas which have reduced the overall risk relating to IT Infrastructure and Asset Management, with work having been undertaken to remove older equipment and enable better monitoring of the infrastructure.

However, there are still a number of actions that need attention in order to fully resolve the risks. We do note however that there is a requirement for the identification of funding in order to fully resolve the issues.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 Old equipment	High	⇧	Medium
2 Risk management	Medium	⇧	Closed
3 Monitoring of equipment	Medium	⇧	Closed
4 Switch patching	High	⇧	Medium
5 Server/Hub rooms	High	⇧	Medium
6 Substandard cabling	Medium	⇧	Low
7 Network security	High	⇧	Medium

2.1 Introduction

1.1 The follow-up review of IT Infrastructure and Asset Management was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'health board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 This was a follow-up review of the original report that was issued in September 2022. This identified seven issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The relevant lead director for the review is the Executive Director of Finance, Information & IT Services.

2.2 Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	-	4	-
Medium	3	2	1	-
Low	-	-	-	-
Total	**7**	**2**	**5**	**-**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Matters Arising with Actions Remaining

Previous Matter Arising 1: Old equipment.		
Original Recommendation		Original Priority
A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.		**High**
Management Response	Target Date	Responsible Officer
Agreed - Original replacement plan was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Secured DPIF Capital funding in 21/22 to help improve and enhance current infrastructure (but not to fully rectify and resolve), global market conditions and supplier delays resulted in alternative plans being deployed (linked to infrastructure development) to maximise use of the funding as available within time constraints. Further DPIF bids are being prepared for submission in 23/24 and beyond. There are also plans to move to the HCI platform to allow the legacy equipment to be decommissioned. This will also improve power and cooling. A realistic infrastructure replacement plan is being developed linked to the 4C report and this will be across a number of years and potential funding sources available.	Servers & HCI March 2023 Switches reliant on investment and there is still a global chip shortage with this equipment target date to be confirmed as per plan as referenced.	Assistant Director Digital Transformation **/** Head of Infrastructure
Current findings		**Residual Risk**
Progress has been made in decommissioning Server 2008 Operating systems, we also note that there has been a reduction in the number of 2012 R2 servers. However, there remain a small number of 2012 R2 servers in operation which no longer receive updates, bug fixes, technical support, or online technical content updates as of October 2023. Removal of the older equipment is complicated by the requirement to upgrade the applications which they host, with a dependency thus with the supplier. The financial dependency is known, and has been planned and secured to complete the small number of remaining upgrades .		Potential risk of: • Loss of service • Inappropriate access to systems / data.

New Recommendation(s)			Priority
1	A realistic time and cost constrained replacement programme for infrastructure equipment should be developed. Work to complete the upgrade of the servers should continue.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
1	There will be a realistic replacement programme developed, and this will be included in the overall Digital Portfolio of Projects underpinning the delivery of the Digital Strategic Framework. We have funding aligned and procurements are in flight for all services hosted on legacy operating systems ie Phone System, Finance systems & RDS Farm. The current forecast is that these will be removed in Q1/2 24/25.	Q4 2024/2025	Chief Technology Officer

Previous Matter Arising 4: Switch patching		
Original Recommendation		Original Priority
A process for ensuring patching of switches should be established.		**High**
Management Response	Target Date	Responsible Officer
Agreed - Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid.	DPIF bid submission March 2023 for a decision on investment for 23/24 subject to WG approval Patching can't take place for eol kit until new switches are procured	Assistant Director Digital Transformation.
Current findings		**Residual Risk**
We note that there has been replacement of some of the older switches and the others are being updated where possible, but again there is a requirement for funding before this can be completed. All new switches are updated before deployment and there is an acknowledgement that an update schedule would be beneficial to keep track of the progress made. Current responsibility for patching is within the S33 agreement but with the appointment of a new Head of Infrastructure and Cyber this will transition to the PTHB Digital Transformation team. However, there is no indication of when this will take place. Mills,Belinda 11/03/2024 17:12:59		Potential risk of: • Loss of service • Inappropriate access to systems / data.

New Recommendation(s)			Priority
2	Following the transfer of responsibility for patching, a patch schedule which keeps track of the current state of the patches deployed and enables patching of switches should be developed.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
2	A maintenance schedule is partially developed to support a much improved patch schedule this will be further strengthened to track and evidence a rolling cycle of firmware updates for PTHB's Network.	Q3 2024/2025	Chief Technology Officer

<table>
<tr><th colspan="3">Previous Matter Arising 5: Server / hub rooms</th></tr>
<tr><td colspan="2">Original Recommendation</td><td>Original Priority</td></tr>
<tr><td colspan="2">Fire and water detection should be included at both sites.
Consideration should be given to providing a dedicated power supply to the Bronllys room.
Fire suppression should be installed at Brecon.
The air conditioning within Brecon should be reviewed to ensure it is capable of reducing the temperature appropriately.</td><td>High</td></tr>
<tr><td>Management Response</td><td>Target Date</td><td>Responsible Officer</td></tr>
<tr><td>Agreed - Fire detection and suppression are in place at Bronllys, but no water detection.
Air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient
There are plans to move on premise servers held within the Data Centre to the cloud so this will reduce the risk of on-premises DC’s
A plan will be developed with Estates and Facilities to assess the water detection requirements and to test and provide assurance relating to the power requirements (initial meeting already taken place).</td><td>March 2023</td><td>Assistant Director Digital Transformation / Assistant Director of Estates and Facilities</td></tr>
<tr><th colspan="2">Current findings</th><th>Residual Risk</th></tr>
<tr><td colspan="2">Assurance has been given by Estates that the air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient.
The status of the rooms remains the same. Fire detection and suppression are in place at Bronllys, there is no fire suppression in Brecon and neither site has provision for water detection.</td><td>Potential risk of:
• Loss of service
• Inappropriate access to systems / data.</td></tr>
</table>

Facilities are to assess the water detection requirements and to test the power requirements for both sites. However there has been no further progress in this area, discussions are on-going but require significant financial and resource investment from estates department in order to improve the current position.			
New Recommendation(s)			**Priority**
3	Fire and water detection should be included at both sites. Consideration should be given to providing a dedicated power supply to the Bronllys room. Fire suppression should be installed at Brecon.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
3	Further investigations and risk analysis will be facilitated to understand the practical implications, cost and feasibility of installing fire and water detection in digital computer rooms. Please note considerable work has been undertaken to tidy up the Digital Computer rooms to improve access and to mitigate BC and H&S risk. Work to assess the feasibility of providing dedicated power supply into Bronllys Hafren Server Room has concluded that it is currently not feasible. Uninterruptable power supplies and local generator mitigate any cyber security risks. The operational risks associated with a non-optimal power feed shall be accepted.	Q2 2023/2024	Chief Technology Officer

Previous Matter Arising 6: Cabling		
Original Recommendation		Original Priority
A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network. A review and associated upgrade of Wi-Fi provision should be undertaken.		**Medium**
Management Response	Target Date	Responsible Officer
Agreed - Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Plan/business case for re cabling to be completed by March 2023 Investment bid To Be confirmed	Assistant Director Digital Transformation
Current findings		**Residual Risk**
As noted in the original response, a Wi-Fi review has been completed and improvements have been made following that. We also note the removal of 14 unsupported devices. A programme of cabling has been established, but the lack of secured funding means that no timescale can be applied to this.		Potential risk of: • Loss of service • Inappropriate access to systems / data.
New Recommendation(s)		**Priority**
4	Develop a priority list for the cabling with associated costings.	**Low**

	Management Response	Target Date	Responsible Officer
4	Cabling improvements are well under way and making excellent progress. Working through priority lists in partnership with Estates and Facilities, Our Exec team and Service Areas. Risk assessments that impact the priority list include areas with hazardous substances such as asbestos, as we have the oldest Estate in Wales The current focus is to deliver blanket wifi coverage to wards to unblock some of our wider transformation and modernisation agenda. (Four wards are already seeing the benefits of our work) and as part of this work we are performing cabinet refreshes to improve cab organisation and supported hardware there.	Q3 2024/2025	Chief Technology Officer

Previous Matter Arising 7: Network security		
Original Recommendation		Original Priority
The network should be split into Vlans. The firewalls should be deployed.		**High**
Management Response	Target Date	Responsible Officer
Agreed – Network re-design plan is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	March 2023	Assistant Director Digital Transformation
Current findings		**Residual Risk**
Work has been undertaken to introduce network segmentation, with the network now being segmented via server VLANs. We note plans to segment wireless and desktop activity in the future but no confirmed date as to when this will be completed. This work will take place over a number of years to address all sites within PTHB. A number of technical challenges have been discovered that are actively being worked on to deliver the level of segmentation required. Work on the deployment of the firewalls has begun. With the management of the firewalls remaining within the Section 33 agreement, but there is an agreement for the work to be moved to PTHB Digital Transformation team under the leadership of the PTHB Head of Infrastructure and Cyber.		Potential risk of: • Loss of service • Inappropriate access to systems / data.

New Recommendation(s)			Priority
5	Develop a realistic, costed plan with achievable time scales to undertake the redesign of the network. Provide clear reports on what the challenges are, along with potential solutions and time lines.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
5	Network segmentation has been implemented and as of late December we have a migration project to align our infrastructure to our new network topology. Project Management & technical resource is aligned, and I expect this work to complete late q3 or early q4 in FY24/25. I migrated our first workload between Christmas and new year. Reporting will be via progress updates aligned to the Digital Strategic Framework presented to the Delivery and Performance Committee	Q4 2024/2025	Chief Technology Officer

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Follow-up: Cyber Security
Final Internal Audit Report

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB 2324 - 11
Report status:	Final
Fieldwork commencement:	26th January 2024
Fieldwork completion:	14th February 2024
Draft report issued:	19th February 2024
Management response received:	19th February 2024
Final report issued:	26th February 2024
Auditors:	Kevin Bridgman IT Audit Manager Martyn Lewis, Senior IT Audit Manager
Executive sign-off:	Pete Hopgood, Executive Director of Finance, Information & IT
Distribution:	Vicki Cooper, CDO & Assistant Director Digital Transformation David Owen, Chief Technology Officer
Committee:	Audit and Risk 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 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 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 and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.
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

To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Limited Assurance Cyber Security (PTHB2223-10) review. That was reported as part of our 2022/23 work programme.

Overview of findings

Generally, there has been progress made in a number of areas.

1. Reporting includes KPIs which have been developed for cyber security in order to show the security status of the organisation.
2. Recording of assets has improved with the introduction of asset management software. Although we note that this work is not yet complete.
3. Replication has restarted, and there are regular test restores to ensure backups are viable. Backups are being passed to tape and stored off site and in an encrypted format. However, the current backup solution does not permit the encryption of data stored to disk. As this is not achievable with the current hardware and solution we have not raised a further matter here.

Follow-up Report Classification

Reasonable Assurance

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 Granular reporting	Medium	⇧	Closed
2 Asset management	High	⇧	Medium
3 Backup storage and testing	High	⇧	Closed

2.1 Introduction

1.1 The follow-up review of Cyber Security was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'health board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 This was a follow-up review of the original report that was issued in March 2023. This identified three issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The relevant lead director for the review is the Executive Director of Finance, Information & IT Services.

2.2 Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	1	1	-
Medium	1	1	0	-
Low	-	-	-	-
Total	**3**	**2**	**1**	**-**

2.1 We have closed two matters arising from the previous audit report. We note that work is still ongoing in those areas however this is sufficiently advanced to have met the requirement of the audit, and so we have not raised a matter.

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Matters Arising with Actions Remaining

Previous Matter Arising 2: Asset management (Operation)		
Original Recommendation		Original Priority
2.1 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.		**High**
Management Response	Target Date	Responsible Officer
2.1 Agreed and Actioned 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.	31-4-23	David Owen (Head of Infrastructure & Cyber Security) Joe Nicholson (ICT Service Delivery Manager).
Current findings		**Residual Risk**
A new Digital asset policy has been developed to support asset management procedures. In parallel, the Health Board have taken steps to reach 100% asset management register and they are currently at 99.5% compliance for their client estate. Infrastructure inventory is around 60% complete for Brecon and Bronllys.		Potential risk of: • Not all devices are recorded on the asset register.

New Recommendation(s)			Priority
2	There has been improvement in the recording of assets. The work should continue to record all the assets across the estate especially in Brecon and Bronllys.		**Medium**
Management Response		**Target Date**	**Responsible Officer**
2	Agreed and Actioned. The 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.	01/10/2024	Chief Technical Officer

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Estates Condition
Final Internal Audit Report

March 2024

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB-SSU-2324-02
Report status:	Final
Fieldwork commencement:	15th May 2023
Fieldwork completion:	18th October 2023
Draft report issued:	19th October 2023, 30th October 2023 & 25th January 2024
Management response received:	6th March 2024
Final report issued:	6th March 2024
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Hayley Thomas, Chief Executive Officer
Distribution:	Wayne Tannahill, Associate Director of Estates & Property Helen Bushell, Director of Corporate Governance Geraint Davies, Head of Estates Anthony Fenn, Head of Technical Services Louise Morris, Capital Programme Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of 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 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 and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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 NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the THB confirmed a total backlog maintenance requirement of £52m- although the capital investment requirement to clear the backlog is likely to be materially higher.

The audit sought to evaluate the arrangements put in place by the THB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Key to understanding the challenge is the quality of the baseline data. The THB's current estates condition baseline data was developed from a 2018 six facet condition survey which had been updated annually by desktop review. At the time of reporting the THB were awaiting the results of a six-facet survey undertaken in early 2023 in order to establish an updated baseline during 2023/24. Experience of other NHS organisations suggests that this update is likely to result in an increase in the reported data. Further concerns have been raised on the comparability of the data, given the significantly varied methods of computation by each NHS organisation.

In the short to medium term, the THB uses a combination of all Wales capital

Report Classification

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary [1]

	Assurance objectives	Assurance
1	Governance	Reasonable
2	Baseline Information	Reasonable
3	Estates Strategy	Reasonable
4	Funding Strategy	Limited
5	Monitoring & Reporting	Reasonable
6	Risk Management	Reasonable

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

	Key Matters Arising	Assurance Objective	Priority
1	Establishment of internal procedures surrounding the annual backlog appraisal/costings; to inform the Estates Facilities Performance Management System.	2	Medium
2	The Health Board should as a priority look to develop an Estates focused service strategy for the medium and long term, to be informed by the up to date Six Facet Estate Condition Survey.	3	High
3	The Board should receive increased assurance as to	4	High

funding, targeted EFAB funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas as follows:

- The THB successfully secured EFAB funding of £2.404m across 2023/24 & 2024/25 to tackle high/significant backlog priorities.
- Across NHS Wales, due to pre-commitments and other pressures on the discretionary capital funding, the allocation for backlog maintenance has historically been insufficient to effectively manage the position – with £525,000 earmarked at the THB specifically for Estates Compliance in 2023/24 (over and above THB contributions to EFAB funding).

In the longer-term, the THB's 10-year programme highlights an indicative funding requirement of circa £233 million for the estate to address the backlog risks and meet the future healthcare needs of the population (it includes the statement that 'Noting the scale of the investment required, there is a significant risk to the THB that this strategy is not deliverable").

A long-term strategy is required for maintenance, as continued investment at historic levels is likely to result in the THB's estates being in a further deteriorating position requiring increased levels of capital investment in the future.

Whilst operational risks were well documented, reported and escalated, the Board should seek further assurance that the identified actions within CRR10 are effective – noting their impact to date.

An overall **limited assurance** has been determined due to the concerns that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Further matters arising concerning the areas for refinement and further

	the risks associated with the absence of agreed funding to support the estates strategy, and the sufficiency of planned mitigating actions.		
4	The THB should develop a clear long term financial model for the revenue support needed in the estate over the short-medium and long term.	4	High
5	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	6	High

development have also been noted (see **Appendix A**).

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. The centrally commissioned surveys have identified only isolated instances of RAAC requiring urgent attention - at the time of reporting, the surveys identified no areas requiring urgent action within the THB's estate.

1. Introduction

1.1 The audit forms a part of the 2023/24 Internal Audit Plan agreed with the Powys Teaching Health Board ('the THB').

1.2 The effective and efficient management of the NHS Wales estate is essential for the delivery of quality health care services.

1.3 The audit was undertaken to evaluate the processes and procedures put in place by the THB to support the management, condition and performance of the estate.

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

- The Board may be unaware and/ or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements);
- Appropriate funding may not be in place;
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood;
- Information may not be interrogated to ensure focus is prioritised on the key risks;
- Performance in addressing identified priorities may not be monitored potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) enables the THB to submit its annual declaration on key data to Welsh Government. The THB reported position over the last three years, against NHS Wales averages, was as follows:

Table 1

Measure	2019/20	2020/21	2021/22
THB cost to eradicate High Risk Backlog (£)	4,603,571	4,833,749	5,075,437
THB cost to eradicate Significant Risk Backlog (£)	21,763,062	22,835,455	23,998,187
THB Total Backlog Cost (£)	47,192,959	49,566,840	52,045,146
NHS Wales average: Total Backlog Cost (£)	78,098,898	97,385,329	113,007,158
THB Risk Adjusted Backlog Cost (£)	27,294,016	28,683,669	30,117,985
THB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	27.77	26.58	31.54

NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

1.6 EFPMS data for 2022/23 had not been submitted at the time of audit.

1.7 Additional estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (published by NWSSP: Specialist Estates Services).

1.8 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations.

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Governance: *Assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the estates condition.*

2.2 The Board had an Independent Member for capital and estates, highlighting the Board commitment to capital and estates scrutiny.

2.3 Whilst the substantive CEO is on secondment, the Associate Director of Capital, Estates, and Property has responsibility for Operational Capital & Estates.

2.4 Prior to secondment in early 2023, the CEO chaired the Innovative Environments Group (IEG) and personally reported on issues in respect of Capital Estates to the Executive Group and the Board. In the interim the Associate Director of Capital, Estates & Property, has taken on the role of Chairing the IEG. This provides a unique linkage between the Board and the forum for discussing estates issues.

2.5 Board assurance was informed via the inclusion of estate condition risks on the Corporate Risk Register (see ***risk management*** section), and routine reporting to the Innovative Environments Group regarding the need for a 6-facet survey and development of an Estates Strategy (see ***monitoring & reporting***).

2.6 Defined organisational structures were in place within the THB covering the management of Estates and Capital.

2.7 Recognising that local and national resource constraints were evident, the THB had completed a review of their Estates workforce in June 2022. (See ***funding strategy***).

2.8 Whilst no issues were identified associated with the specific governance arrangements in place, sound decision making is predicated upon the quality of management information. Accordingly noting management information issues in subsequent sections of this report, **reasonable assurance** has been determined in relation to the current estate governance arrangements.

Baseline Information: *To obtain assurance that the THB had detailed records of the condition on the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that were subject to regular review.*

2.9 The key guidance in relation to assessing backlog: '*A risk-based methodology for establishing and managing backlog'* (updated March 2013), describes the steps involved in establishing and managing backlog, as follows:

2.10 In respect of the detailed condition survey, the guidance recommends that:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis."*

2.11 Detailed six facet estates condition surveys were undertaken on the THB's Estate between 2017-2018.

2.12 The THB has the oldest average NHS estate in Wales i.e., the pre-1948 profile of the estate across Wales was 12%, whilst for Powys the figure was 38%.

2.13 Recognising the five years that had elapsed since the completion of the last Estates Condition Survey, and in keeping with the recommended guidance (as detailed

above); the THB appointed an external specialist company during 2023 to undertake a fresh 6-facet survey across the entire estate.

2.14 The surveys were undertaken in accordance with the above guidance and will provide management with a detailed risk-assessed picture of the condition of the estate and compliance with statutory / mandatory requirements (e.g., fire safety), along with the associated costs in undertaking remedial works.

2.15 Where other NHS Wales health bodies had commissioned recent external costed surveys the backlog maintenance figures had significantly worsened; this presents the potential for health bodies (including PTHB) to be underestimating the cost implications of the backlog maintenance requirements.

2.16 Once the THB establishes an accurate baseline, it is important this is kept up to date to enable effective monitoring, reporting and investment planning. The guidance recommends that:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose."*

2.17 There were also ongoing statutory compliance surveys undertaken on a routine basis; budgeted within the discretionary capital programme and performance monitored and reported to the THB's Innovative Environments Group.

2.18 Management highlighted that an annual meeting takes place to update results for the EFPMS submission. However, there were no procedures to govern this review, to ensure it was undertaken in a consistent manner in the intervening years before detailed surveys are undertaken. (**MA1.1, MA1.2**).

2.19 Given that the THB had identified the need for updating the estates condition surveys, **reasonable assurance** had been determined in relation to baseline information, noting the potentially negative impact on current estimates.

Estates Strategy: *To ensure that a tailored estates strategy was in place including linkage to major investment, estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.20 Welsh Health Building Note 00-08 '*Estate code*' (2018) highlights that:

> *"Once a comprehensive analysis of the condition and performance of the existing estate has been completed, the organisation will have the baseline data used when developing an estate strategy.*
>
> *An estate strategy should represent the vision for the future of the organisation's estate…in order to deliver and satisfy the current and perceived business plans, the expected operational service requirements, aligned with objectives of contributors to health and social care delivery.*
>
> *The purpose of an organisation's board approved estate strategy is to provide the strategic framework for the provision of an efficient, sustainable and fit-for-purpose estate that is both safe and secure. Current drivers include improving efficiency and rationalising occupancy whilst reducing ongoing revenue and capital commitments.*
>
> *The estate strategy should be reviewed annually using EFPMS data and the information from the five-facet survey. The clinical strategy should be the driver of the estate."*

2.21 An interim PTHB Innovative Environments Strategy Framework was developed in September 2020, however the THB's Integrated Plan 2023-2026 (Yr. 1 Delivery Plan 2023-24) noted under Strategic Priority and Key Action (23 Capital & Estates Programme) that one of the key milestones will be to Develop an Estates Strategy to prioritise delivery.

2.22 Whilst there has not been a formal estates strategy developed, PTHB has been able to attract substantial support for the maintenance and development of the estate across Powys in recent years. This has included increases in discretionary capital, as well as investments in Llandrindod Hospital (Phase 1), Machynlleth Hospital, Brecon car park and revenue support for the Llanfair Caereinion Primary Care centre.

2.23 Pre-emptive work has also been funded, for example, for fire compartmentation surveys - that led directly to the fire compartmentation project.

2.24 This milestone was noted in THB's Integrated plan; *the Delivery of urgent compliance capital projects including EFAB (Estates Funding Advisory Board), focusing on essential improvements to infrastructure, fire safety and decarbonisation.*

2.25 It also recognised that the THB have been proactive within the wider estates remit working with strategic partners to produce development control plans and through the commissioning of biodiversity surveys as part of the THB's ambitions in keeping with the Future Generations Act in Wales.

2.26 The Health Board's draft Three Year Plan (2023-2026) - Capital & Estates; detailed capital programme requirements and associated Welsh Government funding requirements. It also highlighted a number of the high and significant risk areas

requiring EFAB, discretionary capital and all Wales capital funding business case submissions.

2.27 Estates was an integral part of the Health Board's delivery plan, with several IMTP (Integrated Medium-term Plan) priorities specifically focused on improving the estate. An estates strategy was being developed, and clear processes were in place to determine how investment would be prioritised, within the constraints of the current capital funding. (**MA2.1**)

2.28 It was concluded that the THB had identified the need for developing an estates strategy to be informed by the 10-year capital plan, with the prioritisation being clearly addressed. Further work however is required to ensure the vision is achievable noting the significant risks to the THB in obtaining sufficient funding to address all maintenance requirements. However, given the steps taken to date, **reasonable assurance** has been determined in relation to the estate's strategy.

Funding strategy: *To ensure there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the estates strategy.*

2.29 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS estate condition. The cost of the THB's backlog maintenance was estimated as £52,045,146 in 2021/22 (see table 1 section 1.5).

2.30 The draft IMTP presented to the THB's Board meeting on the 29th of March 2023 noted under the Innovative Environments section that *there are difficulties maintaining building stock with £73m of backlog maintenance and many competing priorities for a limited amount of Discretionary Capital* **(MA3.1)**.

2.31 The THB submitted a 10-year capital plan to Welsh Government that identified an indicative capital funding requirement of circa £233 million. This included the THB's largest capital investment proposal associated with the 'North Powys Multi-Agency Wellbeing Hub' (currently at Programme Business Case (PBC) Stage). Corresponding funding at this level had not been secured and no assurances had been received that funding would be made available. There remained therefore a material risk that the future Estates Strategy and submitted Capital Plan was unaffordable, noting the current financial climate and considering total funding requirements across Wales.

2.32 Alternative funding streams had been made available to the THB such as the Welsh Government administered Estates and Facilities Advisory Board (EFAB) (relating to works to address fire safety, infrastructure, and decarbonisation).

2.33 The THB has been successful in securing £2.404m investment through EFAB, covering the period 2023-2025. The EFAB funding had been prioritised by the THB to address high/significant backlog risk areas. However, due to the availability of funding and the timeframe in which monies had to be spent, this can lead to difficult priority decisions.

2.34 To secure this funding, the THB were required to contribute from its Discretionary Capital funds, equivalent to 30% of the value of the schemes identified. this equated to £0.268m (2023/24) and £0.453m (2024/25).

2.35 Discretionary capital funding was also available to the THB on an annual basis as part of its Capital Resource Limit. The funding available was reduced by Welsh Government in 2022/23, however for 2023/24 this has been partially increased with extra funding in 2024/25 to lift this back to pre-covid levels. For 2023/24 the Discretionary figure available was £1.260m.

2.36 The THB's Discretionary Capital Programme for 2023 –2025 does note the risk that *Discretionary Capital carries a risk burden for any cost overrun implications form major project activity.* The THB report that this is partly mitigated by the level of contingency provided within approved bids.

2.37 A series of prioritised mini business cases (SBAR) had also been developed by the THB to address several of the most significant and urgent risk areas. The funding requirement was estimated to be £2.582M to be programmed over 2 years.

2.38 The Estates and Facilities Performance Management System (EFPMS) categorises the 'Total Building & Engineering Maintenance Cost per Occupied Floor Area' over the last three years" i.e.

Measure	2019/20	2020/21	2021/22
THB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	27.77	26.58	31.54
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

2.39 Whilst this measure highlights the THB being marginally above the all-Wales average in 2019/20 and 2021/22, this level of investment had been insufficient to prevent a deterioration in the condition of the estate over time. The current level of investment would presumably therefore also be insufficient to effectively manage the condition of any new estate requirements identified within the Estates Strategy.

2.40 The THB recognised the need to develop a long-term financial model for the revenue support needed for the Estates Strategy, this was supported by a paper developed and presented by the THB Estates Department at the Innovative Environments Group Meeting in June 2022.

2.41 The purpose of this paper was to review and assess the suitability of the existing PTHB Estates department structure to meet the operational needs of the organisation in relation to estates compliance and other associated risks in an ageing property portfolio.

2.42 A review of the Corporate Risk Register noted that CRR010 presented to the Board meeting of 24th May 2023 recorded that the resource review was concluded but that the proposal was limited by the THB's financial position **(MA4.1).**

2.43 It was concluded therefore that the THB had utilised a range of funding options for their estate. However, acknowledging the historical underinvestment, the material gap in approved levels of investment and the significant risks to the THB in obtaining sufficient funding to address all maintenance requirements, **limited assurance** has been determined in relation to funding strategy.

Monitoring and reporting: *To ensure appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.44 Statutory compliance was monitored and reported on a regular basis (monthly) at the Innovative Environments Group (chaired by the Chief Executive Officer) and has other executive membership.

2.45 The THB also operated several Estates compliance subgroups covering Electrical Safety, Ventilation, Health & safety and general. These were supplemented with further subgroups incorporating, Fire Safety, Water safety, Asbestos, Medical Gases, Radon and the Capital Control Group.

2.46 The Subgroups were generally of a technical nature relating specific estates compliance requirements. The IEG considers reports and recommendations from the associated subgroups.

2.47 The Delivery and Performance Committee subsequently received updates from the Assistant Director of Estates, Capital & Property on areas of work which were considered by the Innovative Environments Group.

2.48 The updates to the Committee included a capital programme dashboard and a summary of progress of each of the major capital projects. The updates also included detailed information relating to the condition of the estate, such as fire compliance and backlog maintenance.

2.49 It is concluded therefore that there were sound arrangements in place to maintain oversight of capital projects and the condition of the estate, **reasonable assurance** has therefore been determined in this area.

Risk management: *Assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the THB in relation to estates condition was clearly reported.*

2.50 Capital and estates risks are generally identified, assessed, and escalated in accordance with the THB-wide approach to risk management. The Assistant Director of Estates and Property utilised this assessment to focus existing resource and target specific capital priorities.

2.51 At an operational level within Capital and Estates, subgroups were tasked with identifying the 'top 5' high or significant risks and capturing these in a standard

format Highlight Report – these reports act to inform and provide visibility and escalation of risk to the appropriate groups within the organisation.

2.52 The THB's corporate risk register was regularly reported to the Board, including high-level summaries of key risks.

2.53 The key risk detailed on the corporate risk register in relation to estate condition at the time of the audit was:

- CRR010 The care provided in some areas is compromised due to the Health Board's Estate not being fit for purpose. (risk rating 16)

2.54 This single risk (CRR010) encompasses a wide range of risks associated with the estate. In the last year, the target risk had been reviewed/ reassessed to a score of 9 (from 6) to reflect the difficulty in addressing the issue.

2.55 The risk fell within the remit of the Delivery & Performance Committee to oversee and receive routine reviews at the forum.

2.56 Further assurance that the Board was informed on estates related risks is provided by the CEO chairing the Innovative Environments Group and therefore being personally appraised of the risks.

2.57 A high-level action plan was in place for the above. However, noting the effectiveness of the actions to reduce the risk to date, the continued deterioration of the estate condition in the same period, aligned with increasing pressures on available capital resource, the above should be reviewed to provide assurance to the Board that the actions are progressively achieving the desired risk mitigation. It is recommended that the THB identify and separate the key risk issues/ business critical items within the overall risk, to help focus Board attention – management outlined a similar approach was previously taken in the past in relation to fire issues (**MA5.1**).

2.58 Accordingly, recognising that the risk management process is operating as intended and that the Trust has pro-actively sought to review and amend the estates risk in the period, a **reasonable assurance** had been determined in relation to risk management. However, there is a need to review the target risk to ensure it is achievable based on the mitigating action proposed.

Appendix A: Management Action Plan

Matter Arising 1: Baseline Information – Procedures (Operation)	Impact
The Risk Based Methodology to Backlog guidance outlines a process for updating the findings of the detailed survey (condition and risk rankings and associated costings) on an annual basis. This guidance highlights that an annual update should take account of the following, for example: 1. inflation. 2. service schedules. 3. vacant assets awaiting disposal. 4. new sub-standard elements. 5. further deterioration of previously identified elements. 6. recent acquisition of property. 7. refurbishments/alterations since previous survey. 8. regulatory changes. 9. proposed strategic shift in service provision. Management have informed us that an annual meeting takes place to update results for the EFPMS submission to Welsh Government. However, there were no procedures surrounding how the THB would undertake this review that would set out for example: 1. How and who would be involved in this process. 2. What methods would be used to calculate inflation. 3. How further or new deterioration of the estate would be validated. 4. Where the results of the review would be reported (internally within the THB). The formulation and application of standard procedures would ensure consistency over financial years and help provide benchmarking criteria across the NHS Wales estate. Also, an annual review puts	Potential risk of: • Baseline information is not kept up to date.

pressure on the availability and accuracy of information, it may be prudent for reviews to be undertaken more frequently if resources allow.			
Recommendations			**Priority**
1.1	Procedural guidance should be established that details the backlog review process.		**Medium**
1.2	Consideration should be given as to the frequency of the internal meetings to review backlog e.g., bi-annually or quarterly etc.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	A procedure will be produced to define the requirements of the backlog maintenance annual review.	30th June 2024	Associate Director Capital, Estates and Property
1.2	Internal meetings will take place annually to review backlog maintenance.	30th June 2024	Associate Director Capital, Estates and Property

Matter Arising 2: Development of a Specific Service Strategy for Estates (Design)	Impact
An interim PTHB Innovative Environments Strategy Framework was developed in September 2020, however the THB's Integrated Plan 2023-2026 (Yr. 1 Delivery Plan 2023-24) noted under Strategic Priority and Key Action (23 Capital & Estates Programme) that one of the key milestones will be to develop an Estates Strategy to prioritise delivery. Recognising that the THB had identified the need for the development of an Estate's Strategy, and reported they are about to finalise their 10-year capital plan to inform the Estates Strategy. However, further work was required to crystalise the vision ensuring that what is decided upon is achievable and meets the long-term future strategy for delivery of services within the Health Board.	Potential risk of: • Lack of a coherent strategic framework for the ongoing development and management of Estates.

Recommendation		Priority
2.1	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	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.	30th June 2024	Associate Director Capital, Estates and Property

Matter Arising 3: Funding Strategy (Design)	Impact
The THB had been targeting backlog investment through discretionary and other funding streams such as EFAB funding: • For 2023/24 & 2024/25 Welsh Government awarded EFAB funding of £2.40 to be divided between Backlog, Fire Safety Compliance and Decarbonisation. • Discretionary funding for 2023/24 allocated to Estates Compliance being £525k with a further £268k being utilised form Discretionary Capital as the THB's 30% contribution to the EFAB funding. • The THB, in discussion with NHS Wales Shared Services Partnership, Specialist Estates Services (NWSSP-SES) and WG, have also developed a series of prioritised mini business cases (SBAR) to be programmed over 2 years to address some of the most significant and urgent risks on the compliance pipeline. The cost of these was estimated at £2.581m with funding to come from all Wales Capital funds. As above, there were multiple funding sources available, however, the risk adjusted backlog maintenance position highlighted an increasing negative trend (see table 1 section 1.5). Several business cases were being developed and a 10-year capital programme totalling £233m had been submitted to Welsh Government. We noted that the capital programme included the provision for the North Powys Multi Agency Wellbeing Campus, which had yet to be agreed. There remains a significant risk that the Estates Strategy and capital plan may be unaffordable, in the current financial climate and in consideration of similar funding needs across Wales.	Potential risk of: • The Estates Strategy currently in development will be unaffordable, meaning identified estates condition risks will not be addressed.

Recommendations	Priority
3.1 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.	**High**

Agreed Management Action		Target Date	Responsible Officer
3.1	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.	30th June 2024	Associate Director Capital, Estates and Property

Matter Arising 4: Funding Strategy-Revenue Investment (Design)		Impact
WHBN 00-08 2018 Estatecode highlights the importance of life cycle investment planning as key to managing the performance of the estate. Table 1 of this report presents the THB and All-Wales comparators for maintenance expenditure on the estate: with the THB just above the All-Wales average in 2021/22 (based on reported EFPMS data). The THB recognised the need to develop a long-term financial model for the revenue support needed for the Estates Strategy, this was supported by a THB Estate's Department paper presented to the Innovative Environments Group Meeting in June 2022. The purpose of the paper was to review and assess the suitability of the existing PTHB Estates department structure to meet the operational needs of the organisation in relation to estates compliance and other associated risks of an aging property portfolio. The Corporate Risk Register (CRR010) presented to the Board meeting on 24th May 2023highlighted that the resource review was concluded but that the proposal was limited by the THB's financial position. With this identified gap in physical resource considered alongside an increasing risk revised estates backlog position (also within Table 1), the THB is unlikely to see significant progress in reducing the backlog in the short to medium term. Also, any new or refurbished estate is likely to deteriorate in the future without a change in the level of investment. An inadequate internal maintenance resource can contribute to an increasing backlog position i.e., reduced ability to address reactive and planned maintenance. It was evident through our conversations that local and national workforce issues present the THB with challenges surrounding recruiting and retaining skilled labour to enable effective estates service provision.		Potential risk of: • The THB does not invest sufficient resources in maintaining the estate. • The Estate condition does not improve / worsens
Recommendations		**Priority**
4.1 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.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

4.1	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.	30th June 2024	Associate Director Capital, Estates and Property

Matter Arising 5: Risk Management – Assurance (Operation)	Impact
The THB has a defined Risk Management Framework which provides an outline of the risk management process, conduct of risk assessment and the purpose and use of risk registers. This references the Corporate Risk Register which is a standing agenda item at Board Meetings, and which forms a key part of the Board Assurance Framework. Good practice is acknowledged in that the capital and estates risks were generally identified, assessed, and escalated in accordance with the THB wide approach to risk management. The Assistant Director of Estates & Property utilised this assessment to focus existing resource and target specific capital priorities. Where estate risks could not be managed/mitigated within the department to a tolerable level, these risks were escalated through the existing risk management framework. The Corporate Risk Register provides a summary of the significant risks to the delivery of the health board's strategic objectives. To be included in the Corporate Risk Register a risk must: • represent an issue that has the potential to hinder achievement of one or more of the health board's strategic objectives; • be one that cannot be addressed at directorate level; • further control measures are needed to reduce or eliminate the risk; • a considerable input of resource is needed to treat the risk (finance, people, time, etc.). The care provided in some areas is compromised due to the health board's estate being not fit for purpose detailed under strategic aim quality with risk appetite defined as minimal.	Potential risk of: • Board may not be assured that risk were appropriately managed.

The THB Risk Assurance Framework provides information on the controls and assurances in place to manage and/mitigate the significant risks which would impact upon the delivery of the THB Strategic Objectives and identify any further actions which may be required. Capital asset risks were consolidated; the associated risk first recorded in May 2017. Based on the Board Assurance Strategy the risk was considered 'Catastrophic', with an associated score of 20. The residual risk, recognising the internal controls, was assessed as 16 (Major). The THB target risk score for the above is 9 (High), adjusted up from a previous assessment of 6, based on: • A review and refresh of the estate strategy. • Implement the Capital Programme and develop the long-term capital programme. • Continue to seek WG Capital pipeline programme funding continuity: seek alternative capital funding opportunities to mitigate funding reduction for 2022/23 and develop projects in readiness for any capital slippage in latter part of financial year cycle • Develop capacity and efficiency of the Estates and Capital function • Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address limited establishment staff numbers in Works Team and recruitment challenges. Noting the effectiveness of these actions to reduce the risk to date, the continued deterioration of the estate condition in the same period, aligned with increasing pressures on availability capital resource, the above should be reviewed to provide assurance to the Board that the actions are progressively achieving the desired risk mitigation. The THB should consider identifying and separating the key risk issues/ business critical items within the overall risk, to help focus Board attention – management outlined a similar approach was previously taken in the past in relation to fire issues.	
Recommendations	**Priority**

5.1	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	**High**

Agreed Management Action		Target Date	Responsible Officer
5.1	The risks associated with Estates are recognised under CRR010 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.	31st July 2024	Associate Director Capital, Estates and Property

Appendix B: NHS Estate Dashboard Report 2021/22

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol
Shared Services Partnership
Specialist Estates Services

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Below 75% — Energy consumption of 480 kWh/m² or more
Within 75% - 89% range — Energy consumption within 411-479 kWh/m² range
Above 90% — Energy consumption of 410 kWh/m² or less

Energy Performance and Carbon Dioxide (CO_2) Emissions

	Net Energy Consumption (kWh/m²)	CO_2 Emissions* (kg/m²)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	341	70
BETSI CADWALADR UNIVERSITY HEALTH BOARD	460	95
CARDIFF & VALE UNIVERSITY HEALTH BOARD	373	81
CWM TAF UNIVERSITY HEALTH BOARD	419	85
HYWEL DDA UNIVERSITY HEALTH BOARD	485	106
POWYS TEACHING LHB	448	91
SWANSEA BAY UNIVERSITY HEALTH BOARD	407	83
VELINDRE UNIVERSITY NHS TRUST	411	90
WELSH AMBULANCE SERVICES NHS TRUST	246	57

*Target to be agreed

Backlog Maintenance Costs

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Appendix C: 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 presents 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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

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

Date issued: March 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.

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

Contents

Audit, Risk and Assurance Committee Update

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board. We presented our most recent Audit Plan to the committee in May 2023.

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date of completion
Audit of the 2022-23 Charitable Funds Financial Statements	Director of Finance, Information, and IT	Audit of the financial statements to inform the audit opinion.	In agreement with the Health Board the audit will be delayed until April in order for management to obtain external assurances in relation to the operation of a new financial investment system. This position is in common with a few other NHS charitable funds across Wales.	April 2024
Audit of the 2023-24 Accountability Report and Financial Statements	Director of Finance, Information, and IT	Statutory audit of the financial statements to inform the audit opinion.	Planning to commence March 2024.	Opinion prior to 15 July 2024

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 Unscheduled Care	Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working.	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.	May 2024
		We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 2 – Project Brief issued. Detailed project brief to be issued in March 2024	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Primary Care Services - Follow-up Review	Interim Director of Operations	In 2019, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. Our report published in 2019 made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Draft report issued to Health Board for clearance.	May 2024
Workforce Planning	Director of Workforce & OD	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Final report	March 2024
Structured Assessment – core	Director of Corporate Governance / Board Secretary	This work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Final report	March 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		This work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.		
Structured Assessment 2023 – Deep Dive	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.	Fieldwork underway	May 2024
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;	Planning. Project brief to be issued in May 2024	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.		
Local work	N/A	This work was due to focus on the Health Board's approach to financial efficiencies which has subsequently been included as the Structured Assessment 2023 deep-dive across all NHS bodies. Consequently, we are in the process of refunding this element of the 2023 audit fee back to the Health Board.	N/A	N/A

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
From firefighting to future-proofing – the challenge for Welsh public services	February 2024
Board effectiveness follow-up – Betsi Cadwaladr University Health Board	February 2024
Sustainable development? – making best use of brownfield land and empty buildings.	January 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
Fee Scheme 2024-25	January 2024

Audit Wales
1 Capital Quarter, Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Powys Teaching Health Board

Audit year: 2023

Date issued: December 2023

Document reference: 4075A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

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

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Powys Teaching Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe, and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness, corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between September 2023 and November 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 Overall, we found that **the Health Board has generally effective arrangements to ensure good governance which have strengthened since our last review. However, opportunities exist to improve these arrangements further with a particular focus needed on public access to policies, increasing a focus on primary care, hearing from patients and developing the Board Assurance Framework.**

Board transparency, effectiveness, and cohesion

7 We found that **the Board and Committees generally operate well, there is commitment to improved cohesiveness and transparency but public access to some key documents continues to need improvement. Board and committee papers are generally good quality, with increasing use of data and graphics but oversight of primary care needs strengthening and more could be done to get a broader spectrum of patient experience.**

8 The Board remains committed to conducting its business openly and transparently, with opportunities to enhance arrangements further. The Health Board makes good use of its website, but more could be done to ensure social media and other communication routes are used effectively to promote and encourage engagement in Board business. It would also be beneficial to have unconfirmed minutes publicly available soon after meetings, to avoid long waits between committee meetings.

9 There are good arrangements in place for updating and monitoring compliance with core control frameworks, although opportunities remain to increase public accessibility of policies and ensure the Health Board website has the most recent versions of documents uploaded. The Board and committees are operating well with a balanced and appropriate level of scrutiny. Papers are generally of a good standard, with data and graphics increasingly being used to communicate information. However, the Board could benefit from increased oversight of Primary Care to be assured it is focussing on areas which have significant impact on its population.

10 The Board is committed to hearing from patients and staff, but more could be done to get a broader spectrum of feedback. The Board and committees need to hear both positive and negative experiences. While it positive that the Health Board has reintroduced walkarounds, there is scope for the Health Board to formalise this process. The Board is cohesive after a period of flux and demonstrates a positive commitment to continuous improvement, although there remains scope to strengthen committee effectiveness.

Corporate systems of assurance

11 We found that **the Health Board still does not have an updated Board Assurance Framework, as a result cannot be assured that risks are aligned despite there being risk management arrangements. Updated performance management arrangements make better use of data but updates on the Clinical Quality Framework and tracking of audit recommendations tracking need to be more consistently scrutinised.**

12 The Health Board has not yet completed its update to its Board Assurance Framework (BAF) which is the mechanism to bring together all the relevant information on the risks to achieving the organisation's strategic priorities. This is an ongoing gap in governance. The Health Board is making progress and has developed all the relevant components, but this is yet to be developed into the relevant overarching framework. The Health Board needs to complete this activity.

13 There are good risk management arrangements, and a refresh of the corporate risk register has been undertaken. However, the Health Board needs to ensure its transition from holding risk registers on spreadsheets to a specific risk software happens at pace. The Health Board continues to have robust performance management arrangements and the updated Integrated Performance Report allows for easy identification of challenges and progress.

14 The Health Board has appropriate arrangements in place to oversee implementation of the new duties of candour and quality, and to maintain oversight and scrutiny of quality and safety. But there is a gap in the oversight of the Clinical Quality Framework Implementation Plan which has not been received for some months. There are also good arrangements for tracking progress against audit recommendations, however a delay in presenting the recommendation tracker to Audit, Risk and Assurance Committee (ARAC) could limit the timeliness of information.

Corporate approach to planning

15 We found that **while the Health Board's corporate planning arrangements are good, it has been unable to produce an approvable IMTP.**

16 The Health Board has strengthened its approach to developing its plans. The 10-year strategy continues to be in place which has been used to set the framework for the three-year plan. Progress has been made to increase the involvement of Independent Members in the production of plans and strategies, with good use of Board development sessions. However, despite these arrangements, the Health Board has been unable to produce an approvable IMTP for 2023-26. Instead, it has an Integrated Plan for 2023-26 and is working to an Annual Delivery Plan for 2023-24 approved by Welsh Government.

17 The Health Board continues to have good arrangements in place to monitor delivery of its plans and strategies, with the refreshed Integrated Performance Reports provided bi-monthly and the Quarterly Integrated Plan Progress Reports

providing robust assurance to Board and its committees. Scope continues to exist however for the Health Board to make clearer links between the 'Powys Outcomes' in its three-year plan and measurable impacts in its Annual Delivery Plan.

Corporate approach to managing financial resources

18 We found that **although the Health Board has robust arrangements in place for managing and monitoring its finances, its financial position is increasingly challenging.**

19 The Health Board did not meet its revenue financial duties for 2022-23 and is predicting to not meet them again in 2023-24. Working to a revised deficit control total of £12 million by the end of the year, the Health Board was forecasting it would meet its control target at year-end at Month 10.

20 The Health Board has a robust approach to financial planning, with good engagement with the Board. The Health Board requires a savings target of £7.5 million. At Month 10, the Health Board had identified potential saving schemes totalling £11.5 million, although the recurring impacts was forecast to be only £5.8 million.

21 The Health Board has good arrangements for overseeing and scrutinising financial management. Robust arrangements also continue to be in place for monitoring and scrutinising its financial position, with comprehensive reports which allow for easy identification of challenges and risks.

Recommendations

22 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Transparency of Board business R1 The Health Board should: 1.1. promote all Board meetings and other events, such as the Annual General Meeting, via the Health Board's social media channels and other communication mechanisms. 1.2. make unconfirmed minutes available on the Health Board website soon after meetings to promote more timely transparency of Health Board business.

Recommendations

Board commitment to hearing from patients, service users and staff

R2 The Health Board should introduce patient stories to the Patient Experience, Quality and Safety Committee to enable a broader spectrum of both positive and negative experiences to be heard.

Board Walkarounds

R3 The Health Board should strengthen its board walkaround arrangements by:

3.1. developing a forward programme which involves both Independent Members and Executive Directors and covers a broad range of Health Board services.

3.2. develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.

Committee effectiveness

R4 The Health Board should undertake its committee effectiveness reviews as soon as practically possible, to ensure continuous development in the way in which the committees operate.

Corporate approach to overseeing corporate risks.

R5 The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.

Corporate approach to overseeing the quality and safety of services.

R6 The Health Board should ensure that the Patient Experience, Quality and Safety Committee has timely updates throughout the year on progress against the Clinical Quality Framework 2020-23 Implementation Plan.

Corporate approach to tracking recommendations

R7 The Health Board should ensure that the Audit, Risk and Assurance Committee regularly receives the recommendation tracker throughout the year.

Detailed report

Board transparency, effectiveness, and cohesion

23 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

24 We found that **the Board and committees generally operate well, with a commitment to improved cohesiveness, and transparency but public access to some key documents continues to need improvement. Board and committee papers are generally good quality, with increasing use of data and graphics but oversight of Primary Care needs strengthening and more could be done to get a broader spectrum of patient experience.**

Public transparency of Board business

25 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings;
- business and decision-making being conducted transparently; and
- meeting minutes being made publicly available in a timely manner.

26 We found that **the Board remains committed to conducting its business openly and transparently, with opportunities to enhance arrangements further.**

27 Board meetings continue to be held virtually and livestreamed, with recordings available to view via the Health Board website shortly after. All committee meetings also continue to be held virtually. Committee meetings are not livestreamed, but the public may request to attend virtually via email. Items discussed in private Board and committee meetings are kept to an absolute minimum and reserved for sensitive items only. Items for discussion in private meetings are set out at the end of the public Board meeting agenda.

28 Although meetings are promoted via the website, more could be done using social media and other communication mechanisms to encourage public participation and awareness of Health Board business. Despite the Annual General Meeting receiving promotion on social media, none of the other Board meetings are advertised in this way **(Recommendation 1.1).**

29 Minutes of meetings are made available on subsequent agendas, and these are reviewed by the Chair as a standing item for accuracy and tone. However, opportunities remain to further enhance transparency of Board business. With some committees only meet a few times a year, ensuring unconfirmed minutes are available on the Health Board website soon after meetings would promote more timely transparency of Board and committee business **(Recommendation 1.2).**

30 Board and committee papers are usually publicly available 7 days in advance of meetings, but we did find examples[1] where committee papers were not published within the 7-day time frame. We understand that this is due to resource constraints.

Arrangements to support the conduct of Board business

31 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of a formal, up-to-date, and publicly available:

- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- policies and procedures in place to promote and ensure probity and propriety.

32 We found that **there are good arrangements in place for updating and monitoring compliance with core control frameworks, although opportunities remain to increase public accessibility of policies and ensure the Health Board website has the most recent versions of documents uploaded.**

33 There are formal, up-to-date SOs and SFIs in place. The Board approved these and the Scheme of Delegation in September 2023. The Scheme of Reservation and Delegation of Powers document is available publicly on the Health Board website and reflects the interim arrangements since the secondment of the Chief[2]Executive. At the time of our work, the Standing Financial Instructions on the website however were dated March 2021. This has since been updated to the most recent version **(see Appendix 2 R5b 2022).** In previous years we have highlighted that the Health Board does not have a Stakeholder Reference Group or a Healthcare Professionals Forum in line with Standing Orders. The Health Board has indicated that it does not intend to have these groups although there remains reference to them on its website (see **Appendix 2 R8 2022**).

34 The Audit, Risk and Assurance Committee considered and approved the Register of Interests 2023-24 in July 2023. However, this is not published on the Health Board website. Furthermore, this register only focuses on Board Members. To enhance transparency, the Health Board may want to consider how it captures the interests held by other senior staff in line with other Health Boards. As identified

[1] Joint Patient Experience, Quality and Safety Committee and Workforce and Culture Committee meeting, October 2023; Board, July 23; Audit, Risk and Assurance Committee, July 2023, Workforce and Culture Extraordinary Committee, July 2023; Patient Experience, Quality and Safety Committee, July 2023

[2] In April 2023, the Chief Executive was seconded to Betsi Cadwaladr University Health Board for a period of 6-9 months, subsequently being appointed as the substantive Chief Executive in November 2023

last year, the Health Board's policies (both clinical and non-clinical) are still not available to the public **(**see **Appendix 2 R5a 2022)**. Although there is reference to them on the Health Board's website, they can only be accessed by those with an NHS Wales account.

Effectiveness of Board and committee meetings

35 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

36 We found that **the Board and committees are operating well with a balanced and appropriate level of scrutiny. However, the Board could benefit from increased oversight of Primary Care to be assured it is focussing on areas which have significant impact on its population.**

37 The committees are now well-established following changes to their structure in 2021. However, the Health Board may not meet the required frequency of meetings set out in the Terms of Reference for some committees. For example, the current Terms of Reference requires the Planning, Partnerships and Population Health Committee to meet no less than quarterly. However, for 2023-24 there will only be three meetings due to a postponed meeting. This is the same with the Patient Experience, Quality and Safety (PEQS) Committee which should meet bimonthly, but for 2023-24 PEQS will only meet four times. The Health Board will need to reflect on whether the scheduled meetings are sufficient to satisfy the Committee Terms of References. If so, an amendment to the meeting frequency may be required.

38 The new Chair and Director of Corporate Governance have brought an increased focus on reinforcing the roles and responsibilities of the Board and its committees, as part of a wider programme of Board development. This has strengthened the nature and frequency of challenge by Independent Members in meetings.

39 Committee agendas are mature with Chairs owning their agendas and agenda refinement being an ongoing process. The Board and committees are chaired well, and we observed increasingly appropriate levels of scrutiny, support, and challenge. Chairs' assurance reports from each of the committees are provided to

Board, which give a good overview of key committee business and issues for escalation. Since our previous report, a Chairs forum has been established which includes all Committee Chairs, the Chief Executive, and the Director of Corporate Governance. This arrangement is early in its development and does not have a Terms of Reference but does have a Statement of Purpose and an agenda. The Health Board hopes this arrangement will help drive assurances across committees and contribute to Board development, however it is too early to say how impactful this arrangement has been **(**see **Appendix 2 R6a and R6b 2022)**

40 Agendas and work plan items are broadly aligned to the committee structures, committee terms of reference and the corporate risk register. However, there is still no Board Assurance Framework in place. As a result, it is difficult for the Board to be assured that the committee structure in place is completely aligned to key strategic priorities and risks, and that workplans reflect these areas.

41 One example of a lack of alignment is the Health Board's limited oversight of primary care services at Board and committee level. This is despite primary care services being a significant part of the Health Board's delivery. Only one item under the theme of 'Primary Care' is listed on the Board workplan for 2023-2024 and only four items in the Delivery and Performance Committee for 2023-2024. We are currently undertaking a follow-up review of primary care, which we will be reporting in early 2024.

Quality and timeliness of Board and committee papers

42 We considered whether the Board and committees receive timely, high-quality information that supports effective scrutiny, assurance, and decision making. We were specifically looking for evidence of:

- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

43 We found that **papers are generally of a good standard, with data and graphics increasingly being used to communicate information.**

44 Information presented to the Board and its committees remain of a good standard, with previous issues with timeliness largely resolved (albeit agendas are not always published 7 days in advance). Since last year, the amount of time spent presenting items has been reviewed. More time is now spent scrutinising and discussing the topics on agendas. Board and committees are now hearing more from operational staff, and we heard how this is providing useful insights. Executive Directors are still being held to account, but Board and committees are receiving a more rounded view of activity. Reports to Board and committees are making more use of trends, data, and graphics to communicate information. For example, reports to the Delivery and Performance Committee on Continuing Health Care and Variable Pay contain visual information to communicate findings.

45 Independent Members are proportionate in what they ask from officers It is evident the Health Board can demonstrate continuous development in response to the needs of the Board regarding quality and timeliness of committee papers. However, scope remains to more prominently evidence the extent to which the Sustainable Development (SD) Principle is considered as part of papers and subsequent discussions. This would help ensure that the Health Board is applying the SD Principle in a meaningful way to support effective decision making and promote improvement.

Board commitment to hearing from patients/service users and staff.

46 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- the Board using a range of suitable approaches to hear from patients/service users and staff.

47 We found that **the Board is committed to hearing from patients and staff, but more could be done to get a broader spectrum of feedback.**

48 The Board continues to receive patient stories which provide useful insight into individual experiences. Although stories at Board tend to be complimentary and positive, some Board Members have reflected whether the full spectrum of patient experience is really being presented to the Board. Opportunities exist for the Patient Experience, Quality and Safety (PEQS) Committee to also hear patient stories **(Recommendation 2)**.

49 The PEQS Committee receives the Integrated Quality Report which includes information on patient experience. Despite implementation of a new patient feedback system (CIVICA), the Health Board's limited resources are impacting its ability to realise the systems full potential. Whilst the Health Board recognise this is a developing area, it will need to assess how patient experience information is being robustly gathered in a balanced way to inform decision making.

50 The Workforce and Culture Committee now periodically hears from staff (see **Appendix 2 R7 2022**). Feedback from staff roadshows and Team Climate surveys [3]are also reported to the Workforce and Culture Committee and an implementation plan to support the new 'Speaking Up Safely' framework has recently been scrutinised in a joint session between the Workforce and Culture, and PEQS Committees.

51 Independent Members are now undertaking walkarounds of Health Board sites to get a better understanding of challenges and opportunities for both patients and

[3] Staff were asked to undertake a survey of 32 questions with 6 themes; Purpose and Objectives; Accountability; Wellbeing; Psychological Safety; Learning and Innovation; Collective Leadership and Management

staff (see **Appendix 2 R7 2022**). This includes spending time with service areas such as GPs to understand the patient journey. This is a significant improvement in the Health Board's arrangements to help Independent Members understand patient and staff experience, and to help triangulate information presented in Board and committees.

52 To maximise the impact and benefit of walkarounds, the Health Board should develop these arrangements further by providing a forward programme of walkarounds which involve both Independent Members and Executive Directors and cover a wider range of services. The Health Board should also develop a framework setting out how the walkarounds should operate, and the mechanism for reporting key theme **(Recommendation 3).**

Board cohesiveness and commitment to continuous improvement

53 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

54 We found that **the Board is cohesive after a period of change and demonstrates a positive commitment to continuous improvement, although there remains scope to strengthen committee effectiveness.**

55 The Board works collaboratively with a diverse portfolio of skills and experience. Although gaps exist in Independent Member roles, these have been mitigated where possible. Since the retirement in May 2023 of the previous ARAC Chair, there has been a long-standing gap on the Board for an Independent Member for finance, which given the financial pressures the Health Board faces has been unfortunate. The Health Board has appointed a financial specialist to provide support to the ARAC and Delivery and Performance committee, whilst recruitment of a substantive Independent Member takes place. A further gap exists in the Independent Member (Estates) post. The Health Board is currently reviewing its skills across the Board, in light of its strategic objectives and key areas of assurance to consider how best to address this gap.

56 Changes in the Executive team have been managed well. Last year, we reported that the Health Board was holding several interim appointments. Following the secondment of the Chief Executive in April 2023, further interim appointments were made. The Board appointed:

- the Deputy Chief Executive and Director of Strategy, Partnerships and Primary Care as Interim Chief Executive; and;
- the Director of Finance, IT, and Information as the Interim Deputy Chief Executive.

57 The Health Board has however been able to make some substantive appointments across the Executive team. Progress is also underway to recruit substantively into the Chief Executive role **(**See **Appendix 2 R10 2022).** During the year, a new Chair and Director of Corporate Governance have been appointed, both of whom have had a positive impact on culture and Board development.

58 Much work has been done internally on the development of the Board. Board Development sessions have encouraged self-reflection to understand, amongst other things, learning from governance challenges in other Health Boards and approaches which support integrated team working. Individual support has also been made to Independent Members, with new members offered a corporate induction. Although we heard that they would benefit from a tailored induction allowing them to get up to speed on the way in which the Health Board operates.

59 The Board Development Programme has a diverse range of briefings for the forthcoming year including 'Board Effectiveness' and 'Scrutiny, Challenge and Assurance'. We noted previously that the Health Board undertook a Board effectiveness review in April 2022, which also included a broad review of the committees following changes made to the committees' structure in 2021. Committee effectiveness reviews were due to be undertaken earlier in 2023 but these have not yet taken place (**Recommendation 4**) (see **Appendix 2 R9 2022**). At the time of our work, opportunities also still existed to build in some time at the end of agendas to allow reflections of Board and committee meetings **(**see **Appendix 2 R9b 2022).**

Corporate systems of assurance

60 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

61 We found that **the Health Board still does not have an updated Board Assurance Framework, as a result cannot be assured that risks are aligned despite there being risk management arrangements. Updated performance management arrangements make better use of data but updates on the Clinical Quality Framework and recommendation tracking need to be more consistently scrutinised.**

Corporate approach to overseeing strategic risks

62 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.

63 We found that **the Health Board still does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee workplans.**

64 We reported in 2021 and in 2022 that the BAF had not been updated to reflect the priorities set out in the Health Board's strategy and that the BAF had not been presented to the Board since January 2020. The Health Board had intended to update the BAF by 31 March 2022, but this has still not been done **(**see **Appendix 2 R3 2022)**.

65 The lack of an updated BAF is a key gap in ensuring that risks to delivering the Health Board's strategy are clearly identified, that appropriate assurance mapping has taken place to identify and address gaps in assurance, and that controls are in place to mitigate the risks. In June 2023, Internal Audit undertook a review of Risk Management and Board Assurance Framework and gave limited assurance on the BAF objective within the report. A draft BAF was due to be completed by September 2023, but this has not happened.

66 Whilst we recognise work has been undertaken to ensure the components of the BAF are in place, these need to be brought together in one cohesive framework to strengthen the Board's system of assurance.

Corporate approach to overseeing corporate risks

67 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising corporate risks. We were specifically looking for evidence of:

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

68 We found that **despite risk management arrangements being in place, Health Board risks are still not aligned to an updated BAF, and systems for recording risk need updating at pace.**

69 The Health Board's Risk Management Framework and Risk Appetite was last updated and approved by the Board in November 2022 and was reviewed by Audit, Risk and Assurance Committee (ARAC) in November 2023. The Health Board's Risk Appetite is also published on the Health Board website. In its review

of Risk Management and Board Assurance Framework, the June 2023 Internal Audit report gave overall reasonable assurance.

70 The Risk Management Framework states that risks contained in the Corporate Risk Register (CRR) should align to the BAF. However, as previously noted, the BAF is still not up to date. This creates a gap in risk governance.

71 The Health Board revised its Corporate Risk Register in early 2023 to refresh the current risks and ensure alignment with the updated Integrated Plan 2023-26. This review was led by the Director of Corporate Governance in collaboration with Executive Leads. Executive workshops and Board Development sessions have been held to drive engagement. The review was reported to Board in July 2023.

72 The Corporate Risk Register continues to be considered at every Board meeting and emerging risks are highlighted in the cover reports for ease. Committee Risk Registers are presented at the majority of PEQS Committee meetings and until recently were presented at every Workforce and Culture Committee, however no risk register has been presented to the Workforce and Culture Committee since May 2023. Considering recruitment and retention is a significant risk to the Health Board, it seems prudent to consider whether this frequency arrangement is sufficient.

73 The Risk and Assurance Group has now been reestablished, and the intention is this group will play a wider role looking at patterns of risk across risk registers. One area which needs improving is the system for recording risks. Health Board risks are currently recorded on spreadsheets which requires a manual assessment across directorates. There is some progress moving these risks onto an updated Datix software module but this needs to happen at pace. This would allow the Health Board to hold all risks centrally, making risk scoring easier and alignment to the updated CRR more transparent **(Recommendation 5) (**see **Appendix 2 R4 2022).**

Corporate approach to overseeing organisational performance

74 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

75 We found that **the Health Board continues to have robust performance management arrangements and the updated Integrated Performance Report allows for easy identification of challenges and progress.**

76 The Health Board continues to have robust arrangements for performance management. In July 2023, an Internal Audit report on performance management and reporting gave a substantial assurance rating. The revised Integrated Performance Management Framework (IPMF) was approved by the Board in September 2022 and incorporates the Health Board's Commissioning Assurance Framework. This covers the period 2022-2026 with an annual review. It also aligns with the NHS Wales Performance Framework including ministerial priorities. Performance review mechanisms are in place within the IPMF, from personal appraisals through to assurance at Board. Committee roles and responsibilities in relation to performance are also clearly outlined and this has been well received by Independent Members.

77 The Integrated Performance Report (IPR) continues to provide a good overview of the Health Board's performance against national delivery measures, ministerial priorities, and local quality and safety measures. The report is clear to read and allows for easy identification of performance issues. A summary section and a dashboard of 'Escalated Performance Challenges' is at the start of the report, allowing for exception reporting and more focussed discussion on areas of concern.

78 The Health Board intends to move its performance reporting into Power BI and is actively working with other health bodies to learn from their experience. It is intended this digital format will include actual progress against plans and integrate finance and trend data. There is evidence that some benchmarking information is being used to add context to areas such as strategic planning. This is in response to Independent Members expressing a desire to have more data and benchmarking information available to understand how information applies to the Powys population.

Corporate approach to overseeing the quality and safety of services

79 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

80 We found that **the Health Board has appropriate arrangements in place to oversee implementation of the new duties and to maintain oversight and**

scrutiny of quality and safety but needs to ensure it has timely updates on the Clinical Quality Framework Implementation Plan.

81 The Health Board has appropriate arrangements to ensure compliance with the new duties set out in the new Health and Social Care (Quality and Engagement) Act (2020). Comprehensive training has been provided to the Board regarding the Duties of Quality and Candour, including Board Development sessions and organisational away days. The Health Board has a webpage dedicated to the Duty of Quality. An implementation group was established, and updates have been provided to the PEQS Committee, setting out progress being made and any associated challenges.

82 The Health Board developed a Clinical Quality Framework in 2020, which is accompanied by an implementation plan. The PEQS Committee has received updates on the progress against the implementation plan. The latest update shows many areas where progress has been made including implementing the revised 'Putting Things Right' policy. However, more work remains in several areas, such as refreshing the patient experience framework, clinical leadership in quality improvement projects, and benchmarking. However, no further update on the Clinical Quality Framework 2020-23 implementation plan has been to PEQS Committee since September 2022. The committee will require more regular updates to ensure the Health Board has sufficient oversight on the progress of the implementation plan **(Recommendation 6).**

83 The Integrated Quality Report to the PEQS Committee provides a comprehensive overview of quality and safety across the Health Board, including complaints, concerns, and mortality reviews. A comprehensive update on the clinical audit plan is also presented to the committee.

Corporate approach to tracking recommendations

84 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations in a timely manner.

85 We found that **the arrangements for tracking recommendations are generally good although there needs to be more regular oversight of the tracker report by ARAC.**

86 The Health Board has generally good arrangements in place for tracking audit and review recommendations. In July 2023 Internal Audit gave reasonable assurance on the tracking of Internal Audit Recommendations.

87 A comprehensive update report setting out progress against recommendations relating to internal and external audit, and counter fraud is due to be reported twice yearly to ARAC meeting. This report flags the number of recommendations implemented and those that are overdue. However, this report has not been

presented to ARAC since March 2023. This has been due to scheduling to accommodate for a number of Internal Audit Reports on the agenda. The Health Board is aware of this scheduling issue but needs to ensure it has sufficient and appropriately spaced regular oversight of recommendation tracking at ARAC. **(Recommendation 7).**

Corporate approach to planning

88 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

89 We found that **while the Health Board's corporate planning arrangements are good, it has been unable to produce an approvable IMTP.**

Corporate approach to producing strategies and plans.

90 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

91 We found that **despite being unable to submit a balanced plan, the Health Board has strengthened its approach to developing its plans.**

92 The Health Board continues to work towards delivery of its 10-year strategy, which was used to set the framework for the development of the Health Board's IMTP for 2023-26, along with the Population Needs Assessment and the Powys Well-being Assessment. However, the Health Board recognises that the 10-year strategy would benefit from being updated in response to the changing environment and to reflect financial pressures.

93 The Health Board has strengthened its approach to planning. Before being reported at Board, an Integrated Planning Approach, Framework and Parameters 2023-2026 presentation was delivered to the Planning, Partnerships and Population Health Committee in November 2022. This provided a clear timeline to produce the IMTP for 2023-26 and the key messages from relevant strategies to inform the planning process. This is a useful and accessible document which

provided a comprehensive analysis of Powys needs, including but not limited to workforce and estates challenges, and the financial position.

94 Much progress has been made to increase the involvement of Independent Members in the production of plans and strategies. Board development sessions were used to share the findings of a SWOT[4] analysis undertaken as part of the planning process, as well as key insights from the Population Needs Assessment and Powys Well-being Assessment. In addition, an updated detailed presentation to Board in January 2023 outlined the purpose, approach, and next steps for the IMTP, and draft iterations of the plan were considered at Board Development sessions (see **Appendix 2 R1 2022**). Future Board sessions include a focus on Strategic Objectives for 2024-29 and the Strategic Plan 2024-29.

95 However, despite these arrangements the Health Board was unable to produce a Welsh Government approved IMTP for 2023-26 due to the planned financial deficit. Instead, a draft Integrated Plan for 2023-26 was approved at Board in March 2023 and an underpinning Annual Delivery Plan for 2023-24 was approved by Board in May 2023, prior to submission to the Welsh Government. The Annual Delivery Plan was approved by Welsh Government in July 2023.

96 The Strategic Digital Framework was also approved at the July 2023 Board following Board Development sessions in October 2022 and June 2023. The Framework supports the Health Board's 'Digital First' ambition set out in its 10-year strategy.

Corporate approach to overseeing the delivery of strategies and plans.

97 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[5] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

98 We found that **the Health Board continues to have good arrangements in place to monitor delivery of its plans and strategies.**

99 The Integrated Plan 2023-26 sets strategic priorities and key areas of delivery which have a quarterly timeframe allocated to them. It is supported by the Annual Delivery Plan which mirrors these strategic priorities and key actions but does not have the expected delivery or implementation quarter which would be helpful.

[4] Strengths, Weaknesses, Opportunities and Threats

[5] Specific, measurable, achievable, relevant, and time-bound

There needs to be a clear link between the 'Powys Outcomes' in the Integrated Plan 2023-26 and how these are translated into measurable impacts in the Annual Delivery Plan **(**see **Appendix 2 R2 2022).**

100 Progress on delivery against each of the priorities is reported quarterly to the Delivery and Performance Committee, and the Board via the Quarterly Integrated Plan Progress Reports 2023-24. This report sets out when the Board can expect the actions and plans to be delivered, the responsible officers, and the route through which it can expect to receive appropriate assurance. This report also includes a 'Year End Delivery Confidence Assessment' which is noted as High, Medium, or Low. This is a particularly useful indicator as it provides a perspective from the organisation on its deliverability.

101 The refreshed Quarterly Integrated Plan Progress Reports are more explicit about performance than previous years. The reports are easier to read, make it easier to track key milestone progress and make more use of data in the commentary sections than previous years.

102 Progress against delivery of the Strategic Digital Framework is maintained through bi-annual updates to the Delivery and Performance Committee, with annual updates provided to the Board.

Corporate approach to managing financial resources

103 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

104 We found that **although the Health Board has robust arrangements in place for managing and monitoring its finances, its financial position is increasingly challenging.**

Financial objectives

105 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of the Health Board:

- meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- being on course to meet its objectives and duties in 2023-24.

106 We found that **the Health Board did not meet its revenue financial duties for 2022-23 and is predicting to not meet them again in 2023-24.**

107 Despite submitting a financially balanced plan, the Health Board did not meet its financial duties for revenue for 2022-23. The Health Board reported a year-end deficit of £7.0 million, and a cumulative deficit of £6.8 million for the rolling three-

year period 2020-23. The Health Board reported a small surplus of £68,000 against its capital resource limit.

108 The Health Board has been unable to submit a balanced financial plan for the three-year period 2023-26 and instead is working to an Annual Plan which sets out a predicted deficit of £33.4 million for 2023-24. As in previous years, the areas of pressure remain as Continuing Health Care (CHC) costs, costs associated with commissioned activity (particularly by English providers), and variable pay costs particularly in relation to agency expenditure within mental health services. Since April 2022, there is also increasing cost pressures from primary care prescribing. The increase in costs has been attributed to higher inflation and increased prescribing activity.

109 In Month 7, Welsh Government allocated an additional £18.3 million to offset some of the Health Board's cost pressure. The Health Board revised its forecast deficit to £15.2 million, however Welsh Government have issued the Health Board with a revised deficit control total of £12 million to achieve by the end of the year. At Month 10, the Health Board was forecasting that it will achieve its control total at year-end. The Health Board is also forecasting that it will remain within its capital resource limit of £3.7 million.

Corporate approach to financial planning

110 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

111 We found that **the Health Board has a robust approach to financial planning.**

112 The Health Board has a clear process for developing its financial plan which is regularly reviewed throughout the year. Board members have had good engagement with the development of the plan, and the Board was engaged fully in the scrutiny of the plan prior to submission to Welsh Government.

113 To deliver its agreed deficit, the Health Board requires a savings target of £7.5 million. At Month 10, the Health Board had identified potential saving schemes totalling £11.5 million. Delivery of savings however were ahead of profile by £2.2 million. The detailed savings plan is set out in the financial plan. Savings plans have been developed and are owned jointly by both the operational and finance teams. In addition, there has been renewed collaboration with the Workforce and

Organisational Development team. The Health Board recognises that to deliver the savings will require transformation change by some services. A significant proportion of the Health Board's identified savings are recurring, although the full year effect falls short of the £7.5 million requirement at £5.8 million.

114 The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

115 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

116 We found that **the Health Board has good arrangements for overseeing and scrutinising financial management.**

117 The Health Board has robust arrangements in place to ensure compliance with statutory instruments, and to report breaches. As mentioned in **paragraph 33**, the Standing Financial Instructions and Schemes of Delegation have been reviewed and approved by the Board. The number of Single Tender Actions (STAs), and losses and special payments continue to be routinely scrutinised by the ARAC. The Health Board also continues to have a proactive counter fraud arrangement with updates provided to every ARAC meeting.

118 The Health Board is aware of its cost drivers, and controls are in place to manage the financial position. As the Health Board's biggest area of spend, the Health Board has increased its scrutiny on commissioned services. Monthly meetings with providers are taking place and finance teams are ensuring financial processes are robust. Detailed reports are also presented to the Delivery and Performance Committee and Executive Committee, setting out work to reduce and address challenges with variable pay, medicines management and prescribing, and Continuing Health Care.

119 The Health Board submitted good quality draft financial statements as per the required timeline. Our audit identified no material misstatements but did identify

some areas where corrections should be made. Our audit also made one recommendation in relation to year-end payable balances. We issued an unqualified opinion in respect of the true and fairness of the accounts, but a qualified regulatory opinion due to the Health Board breaching its duty to deliver a break-even position over the three-year rolling period 2020-23.

Board oversight of financial performance

120 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of the Board:

- receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- appropriately scrutinising the ongoing assessments of the organisation's financial position.

121 We found that **the Health Board continues to have robust arrangements for monitoring and scrutinising its financial position, with comprehensive reports in place which allow for easy identification of challenges and risks.**

122 The Health Board continues to have comprehensive and clear financial reports which are presented to both the Board and Delivery and Performance Committee. Work has been done to continually reflect on the layout and presentation of the reports to ensure key messages are relayed and key risks identified. These reports have been well received and support effective scrutiny and challenge from members. The financial reports set out a clear overview of revenue, the forecast position, performance against required savings, capital spend, and includes the monthly monitoring returns. Detailed information is also provided on the key areas of financial pressure, and agency spend is also included in the routine Integrated Performance Report to Board.

123 Risks associated with achieving the financial plan are included on the Health Board's Corporate Risk Register, with the risk increasing since the Health Board reported a forecast deficit position for 2022-23. The financial corporate risk is split into two subsections, one aspect for the failure to manage its financial resources in line with statutory requirements in the current financial year, and the other for the medium term. This is helpful as it allows the Health Board the space to focus on the shorter term and the longer-term financial planning.

Appendix 1

Audit methods

Exhibit 2 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
Observations	We observed Board meetings as well as meetings of the following committees: • Audit, Risk and Assurance Committee; • Delivery and Performance Committee; • Patient Experience, Quality and Safety Committee; • Planning, Partnerships and Population Health Committee; and • Workforce and Culture Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement;

Element of audit approach	Description
	• relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Director of Corporate Governance/Board Secretary; • Chair; • Interim Chief Executive Officer; • Interim Deputy Chief Executive and Executive Director of Finance, IT & Information Services; • Interim Director of Performance & Commissioning; • Vice-Chair of Audit, Risk and Assurance Committee; and • Vice-Chair.

Appendix 2

Progress made on previous year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structured assessment reports

Recommendation		Description of progress
R1	Opportunities exist to engage Independent Members in the early stages of the IMTP planning process to enable the Board to fully discharge its duty to set the strategic direction for the organisation. The Health Board should put appropriate arrangements in place to ensure appropriate Independent Member involvement in all IMTP planning stages.	Complete – see paragraph 94
R2	Delivery reports for monitoring progress against the priorities and actions set out in the IMTP are largely narrative and lack a focus on measures and impact. The Health Board should revisit its delivery reports to ensure they are succinct, less narrative, and have an increased focus on measures and impact.	In progress – see paragraph 99
R3	The Health Board does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee workplans. The Health Board needs to update its Board Assurance Framework.	In progress – see paragraph 64

Recommendation		Description of progress
R4	There is currently a disconnect between directorate risk registers and the Corporate Risk Register (CRR). The Health Board needs to review all high risks on directorate risk registers to ensure the relevant ones are escalated to the CRR, and that the Board is aware of wider risks that may materialise.	In progress – see paragraph 73
R5	Opportunities exist to improve public access to key Health Board documents. The Health Board should ensure that: a) policies and procedures, and the register of interest on the public website are accessible; and b) key documents, including Standing Orders, on the public website are the most recently approved version.	No action – see paragraph 34 Complete – see paragraph 33
R6	There are no mechanisms for committee Chairs to meet formally outside of committee meetings to share concerns and good practice, and there are also no mechanisms in place to track issues and actions referred between committees. The Health Board should put in place a mechanism to enable: a) committee chairs to come together on a regular basis; and b) issues and actions referred between committees to be tracked and feedback provided when completed.	Complete – see paragraph 39 In progress – see paragraph 39
R7	The Board and its committees do not hear from staff, and Board walkarounds have not been reinstated since the pandemic. The Health Board should increase opportunities for Board members to hear from staff. This should include making use of staff stories in Board and committee meetings, and the urgent reinstatement of Board walkarounds.	Complete – see paragraphs 50 - 51

Recommendation		Description of progress
R8	Despite Standing Order requirements, the Health Board still does not have a Healthcare Professionals Forum or a Stakeholder Reference Group. The Health Board should establish both groups as a matter of urgency.	Closed – see paragraph 33
R9	Opportunities exist to improve self-reviews of Board and committee effectiveness. The Health Board should: a) ensure areas for improvement are captured and monitored via an action plan; and b) include a standing agenda item in all Board and committee meetings to allow for a review of the meeting.	No action – see paragraph 59 In progress – see paragraph 59
R10	The Health Board is carrying several interim posts at a senior level which can cause instability for both services and staff. The Health Board should seek to appoint substantively to the interim posts within the Executive team as soon as practical to do so.	In progress – see paragraphs 56 - 57

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Health Board response to our audit recommendations

Recommendation	Organisational 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)
Transparency of Board business R1 The Health Board should: 1.1. promote all Board meetings and other events, such as the Annual General Meeting, via the Health Board's social media channels and other communication mechanisms.	**Recommendation 1.1 accepted** The Health Board acknowledges the importance of promoting meets and relevant events and already uses mechanisms including its website and social media for the AGM given the public meeting nature of the event. Other Board and Committee meetings will continue to be made available through the website and through relevant other mechanisms including public briefings and other public engagement communications. We do not consider social media to be the most effective channel for promoting meetings such as these.	N/A	Director of Corporate Governance

Recommendation	Organisational 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)
1.2. make unconfirmed minutes available on the Health Board website soon after meetings to promote more timely transparency of Health Board business.	**Recommendation 1.2 acknowledged but not accepted.** Unconfirmed minutes – we recognise the good practice this recommendation carries. At this time we do not have the resources available to fulfil this recommendation but will review this again in due course. In the meantime Board meetings livestream videos will continue to be available via the website and summaries of each Committee meeting reported to the next available Board meeting – a maximum of 2 months apart.		
Board commitment to hearing from patients, service users and staff R2 The Health Board should introduce patient stories to the Patient Experience, Quality and Safety Committee to enable a broader spectrum of both positive and negative experiences to be heard.	**Recommendation accepted.** A schedule of patient stories will be planned, aligning (where possible) to key agenda items from April 2024.	From April 2024 and then ongoing	Director of Nursing and Midwifery
Board Walkarounds	**Recommendations accepted**		

Recommendation	Organisational 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)
R3 The Health Board should strengthen its board walkaround arrangements by: 3.1. developing a forward programme which involves both Independent Members and Executive Directors, and covers a broad range of Health Board services; 3.2. develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	Programme is in place for Chair, Vice Chair and CEO, this is being expanded to Independent Members and Executive Directors. A coordinating mechanism is also in place. 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 2024 May 2024	Director of Corporate Governance Director of Nursing and Midwifery / Director of Workforce and OD
Committee effectiveness R4 The Health Board should undertake its committee effectiveness reviews as soon as practically possible, to ensure continuous development in the way in which the committees operate.	**Recommendation accepted** At the time of writing, three Committee reviews have been completed. All others are scheduled and will be reported to the Board in May 2024.	30 May 2024	Director of Corporate Governance

Recommendation	Organisational 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)
Corporate approach to overseeing corporate risks. R5 The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	**Recommendation accepted** The RL Datix system is currently being piloted and staff recruitment is underway to support the project roll out. An action plan for full roll out will be developed.	30 Sept 2024	Director of Corporate Governance / Director of Nursing and Midwifery
Corporate approach to overseeing the quality and safety of services. R6 The Health Board should ensure that the Patient Experience, Quality and Safety Committee has timely updates throughout the year on progress against the Clinical Quality Framework 2020-23 Implementation Plan.	**Recommendation accepted** 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	30 July 2024	Director of Nursing and Midwifery
Corporate approach to tracking recommendations R7 The Health Board should ensure that the Audit, Risk and Assurance	**Recommendation accepted and completed** The tracker will be reported to the Committee in May, September, and January of each year.	Complete	Director of Corporate Governance

Recommendation	Organisational 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)
Committee regularly receives the recommendation tracker throughout the year.	The schedule has been added to the Committee forward plan.		

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Powys Teaching Health Board

Audit year: 2022

Date issued: January 2024

Document reference: 3737A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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

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

Contents

Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,700 vacancies in their 2023 Nursing in Numbers analysis. In addition, the social care sector, which is complimentary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long-term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pension taxation issues.
- shifts in attitudes towards full and part time working.
- developing home grown talent and the ability to attract talent from outside the country into Wales.
- service transformation which can change roles and result in increasing specialisation of roles.

4 In January 2020, the Powys Regional Partnership Board, which Powys Teaching Health Board (the Health Board) is part of, agreed 'Workforce Futures', the strategic framework (the Framework) for Powys health and social care workforce. The Framework underpins Powys's health and care strategy, A Healthy, Caring Powys, 2017-27.

5 The key focus of our review has been on whether the Health Board's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Health Board's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management arrangements such as staff/nurse rostering, consultant job planning

and operational deployment of agency staffing, fall outside the scope of this review. The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

6 Overall, we found that **the Health Board is taking appropriate action to address its significant workforce challenges, with good oversight of its Workforce Futures ambitions. However, there are opportunities to strengthen the Workforce Futures implementation plan and focus more on the impact of actions that the Health Board is taking to reduce its workforce risks.**

Key workforce planning challenges

7 The Health Board is facing significant workforce challenges across a range of services and professions, causing greater workload pressures on existing staff. It faces particular workforce planning challenges owing to its rurality, having a large geographic footprint with a number of community hospitals, which need to be staffed by the Health Board's relatively small workforce. This is further compounded by poor public transport, and a limited supply of qualified staff because the region is sparsely populated, has an aging population, and does not have a university. The workforce indicators presented in **Appendix 2** highlight that despite the Health Board steadily increasing its workforce over the last decade, staff retention is an issue. Compared to other health bodies in Wales, the Health Board has the highest rate of staff turnover (14% in 2021-2022 and 15% in October 2023). Consequently, agency spend has increased to maintain safe staffing levels, from £5.1 million in 2017-18 to £10.7 million in 2022-23. The current forecast is that agency spend is expected to reduce to around £8.6 million in 2023-24, although agency costs would still represent around 11% of the total pay expenditure. Compared to other health bodies, at 11.7% in June 2023, the Health Board has one of the highest vacancy rates, which is due to recruitment challenges owing to issues such as its rurality. The Health Board also has an aging workforce, which further risks reducing the workforce, increasing the need to use agency staff at a time of financial constraint.

Strategic approach to workforce planning

8 **The Health Board has a good and improving approach to workforce planning but there is a need to have a stronger focus on impact.**

9 The Health Board, with its regional partners, has a clear vision to address current and future workforce risks, with an implementation plan to support its delivery. However, there is scope for the implementation plan to clearly set out the outcomes it is intending to achieve and how these will be measured, which in turn will ensure a greater focus on impact. The Health Board has a good understanding of its current demand with forecasts based on its current service model, but it

needs a greater understanding of the future shape of services to support strategic workforce planning and build a sustainable workforce. The Health Board is working proactively with its regional partners to collaboratively address current and future workforce challenges.

Operational action to manage workforce challenges

10 **The Health Board is improving its workforce planning capacity and capability to focus on its significant challenges, however considerable risks related to vacancies remain, resulting in high use of agency staff.**

11 The Health Board is addressing the fragility of its Workforce and Organisational Development (OD) Directorate by strengthening the directorate's operating model and enabling operational service leads to take greater ownership of their workforce planning. The Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date. Despite the Health Board's proactivity, there remains significant recruitment, retention, and education commissioning challenges, which is driving an over-reliance on agency staff.

Monitoring and oversight of workforce plan/strategy delivery

12 **There is effective oversight of workforce performance and the Workforce Futures Programme, however, the Health Board needs to better understand whether its actions are making a difference.**

13 The Workforce and Culture Committee receives comprehensive workforce performance information and has good oversight of the Workforce Futures Programme, but there is a need to better understand the impact of its delivery, and opportunities to benchmark with similar rural healthcare organisations outside of Wales.

Recommendations

Exhibit 1: recommendations

14 **Exhibit 1** details the recommendations arising from this audit. Powys Teaching Health Board response to our recommendations is summarised in **Appendix 3**.

Recommendations	
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 (**see page 11**).
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 (**see page 15**).
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 (**see page 16**).
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 (**see page 19**).
R5	The Health Board should identify organisations across the UK with similar workforce challenges to benchmark its workforce performance and share good practice (**see page 20**).

Detailed report

Our findings

15 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- The Health Board's approach to strategic approach to workforce planning (**Exhibit 2**).
- Operational action to manage workforce challenges (**Exhibit 3**).
- Monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: Strategic approach to workforce planning.

This section focusses on the Health Board's approach to strategic planning. Overall, we found that **the Health Board has a good and improving approach to workforce planning but there is a need to have a stronger focus on impact.**

What we looked at	What we found
We considered whether the Health Board's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • Identifies current and future workforce challenges. • Has a clear vision and objectives. • Is aligned to the organisation's strategic objectives and wider organisational plans.	We found that **the Health Board, with its regional partners, has a clear vision to address current and future workforce risks. Whilst there is an implementation plan to support delivery, there is scope to have a greater focus on impact.** Recognising that a regional approach is needed to address current and future health and care workforce challenges, the Health Board and its partners developed the joint 2020 Workforce Futures strategic framework (the Framework). The Framework, which was agreed through the Powys

What we looked at	What we found
• Is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care. • Is supported by a clear implementation plan.	Regional Partnership Board[1](RPB) in January 2020, supports the workforce ambitions set out in the region's 10-year strategy for health and social care (A Healthy, Caring Powys, 2017-27). The Workforce Futures Framework clearly sets out the challenges facing the region, its population and the health and social care workforce. Workforce challenges highlighted include shortages of doctors, nurses, and care workers, leading to heavy reliance on agency staff. There is also an aging health and care workforce with many predicted to retire over the next five years. At the same time there are no universities in the region meaning many young people and those of working age move away reducing opportunities to recruit locally and recruit Welsh speakers. With a large proportion of Welsh speakers (18%) in the region, health and care services need to be accessible in English and Welsh. These issues are set in the context of health and care services serving an increasingly aging population in a sparsely populated, rural location. The Framework sets out a clear ambition aligned to the Health Board's 10-year strategy for health and social care. To help deliver this, the Framework focuses on six key workforce themes with several actions under each. These seem logical to address the challenges facing the region. The themes are: • Designing, Planning and Attracting the Workforce; • Leading the Workforce; • Engagement and Wellbeing; • Education, Training and Development; • Partnership and Citizenship; and • Technology and Digital Infrastructure (this is a cross cutting theme).

[1] The Health Board, Powys County Council and Powys Association of Voluntary Organisations are members of the Powys Regional Partnership Board (RPB).

What we looked at	What we found
	The Joint Workforce Futures Programme Board[2] has recently reviewed the programme, with the aim of confirming programme priorities and ensuring actions are clear and focus on impact. As a result of the review, the 48 actions detailed in the Framework have been reduced to 14 and programme governance arrangements have been strengthened. These changes appropriately reduce duplication and clarifies key action which will make monitoring and evaluation clearer. As well as supporting the region's 10-year strategy for health and social care, the Framework is well aligned to relevant wider national plans, policies, and legislation. For example, Well-being of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014. Whilst the Framework was developed before the launch of the national Health and Social Care Workforce Strategy[3], it supports the ambitions of A Healthier Wales[4]. Workforce Futures is well embedded within the Health Board's Integrated Plan. There is no separate implementation plan, instead high-level actions are included within the Integrated Medium-Term Plan (Integrated Plan)[5], with the Board receiving updates on key milestones for 2023-24 through its Integrated Plan monitoring report. However, the milestones are task focused and there is little information about how the Health Board will measure the impact of delivery (see recommendation 4).

[2] This joint programme board reports to Powys's Regional Partnership Board and is responsible for overseeing the Workforce Futures programme on a regional basis.

[3] In October 2020, HEIW and Social Care Wales launched the 10-year Workforce Strategy for Health and Social Care. This was developed in response to A Healthier Wales.

[4] A Healthier Wales: Our Plan for Health and Social Care (2018) is the response to the Parliamentary Review of Health and Social Care in Wales (2018), which sets out the case for change in health and social care provision.

[5] Under the following themes: Transformation and Sustainability of Our Workforce, A Great Place to Work, Employee Health and Wellbeing and Joint Workforce Futures Programme.

What we looked at	What we found
We considered whether the Health Board has a good understanding of current and future service demands. We expected to see: • Use of reliable workforce information to determine workforce need and risk in the short and longer term. • Action to improve workforce data quality and address any information gaps.	We found that **the Health Board has a good understanding of its current demand with forecasts based on its current service model, but it needs a greater understanding of the future shape of services.** The Health Board has a good understanding of its current and future service demands and trends. In early 2022, all health boards conducted a nursing workforce modelling exercise[6], with nationally agreed planning assumptions. The Health Board recognised the value of this exercise in informing strategic workforce planning, so replicated the exercise for all clinical and non-clinical services and professions[7]. The Health Board now repeats this exercise twice a year to ensure, for each profession, it has up to date information on budgeted establishment, staff currently in post, workforce trends, and average annual recruitment, turnover and retirement projections. The information can be broken down at service and ward level to help inform service level workforce planning. However, modelling assumptions are based on current service models, unless there is service transformation modelling in place such as for paediatric services. Consequently, the Health Board needs a better understanding of its future service models to support strategic workforce planning. The Health Board has good workforce information, but is starting to improve its consistency, quality and have more of a future focus. The Health Board is using the workforce plan template developed by HEIW to ensure directorate workforce plans are presented in a consistent format to feed into the annual planning cycle. The Health Board had intended for all directorates to conduct this exercise, but recognising service pressures, only areas with variable pay are now required to develop a workforce plan. This is the first-time directorates have been asked to take a consistent approach to workforce planning, as such this year's exercise acts as a baseline to improve on in subsequent years. However, from next year the Health Board should ensure all directorates and/or service areas adopt a consistent approach to developing workforce plans as this will better inform short, medium and longer-term workforce planning (**Recommendation 1**). The Health Board is also working on a five-year workforce plan to inform medium to longer-term planning. This is based on the workforce

[6] To feed into the all-Wales strategic workforce plan for nursing, in early 2022, all health boards in Wales were asked to conduct a workforce modelling exercise for nursing and midwifery, based on a set of nationally agreed planning assumptions.

[7] The Health Board workforce projection modelling exercise covers clinical professions such as doctors, GPs, pharmacists, nursing and allied health professionals, and enabler services such as estates, finance and workforce and organisational development.

What we looked at	What we found
	minimum data set submitted annually to Welsh Government. To support oversight of workforce data and systems, the Health Board is making changes to a vacant senior role within the resourcing team. Whilst this change may enhance data capabilities within the team, the capacity remains the same as this will be just one part of a wider resourcing role. The Health Board is hoping to fill this vacancy in spring 2024.
We considered whether the Health Board is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • Effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues. • Shared solutions identified with key stakeholders to help address workforce challenges.	We found that **the Health Board is working proactively with its regional partners to collaboratively address current and future workforce challenges.** The Health Board has a strong approach to partnership working, demonstrated through its development of the Workforce Futures Framework and overarching health and care strategy for Powys with its RPB partners. Both the strategy and framework were informed by extensive stakeholder engagement. The Framework, which is overseen by a Joint Programme Board, facilitates multi-agency workstreams and initiatives. For example, the provision of apprenticeships, volunteering, and work experience programmes to help encourage people to work in the health and care sector. The Health Board also works with its partners on joint recruitment drives, roadshow events and its school programme. The Health Board and Powys County Council also offer a joint induction programme for health and social care workers. The Health Board is also part of the Mid Wales Workforce Collaborative, alongside Hywel Dda and Betsi Cadwaladr University Health Boards. The collaborative provides a potentially useful platform for the health boards to collectively address workforce challenges, for example by sharing intelligence, exploring joint projects, appointments, and opportunities to rotate staff. The latter would be especially useful for Powys as it would give staff exposure to wider work experience, making working for the Health Board more attractive. However, the Health Board reported that the work of the collaborative had slowed down during 2023. The collaborative met in December 2023 to reset its priorities. In addition, there are transformation programmes in the region which will have workforce

What we looked at	What we found
	implications for the Health Board and will need workforce modelling and plans. For example, the North Powys Wellbeing Programme[8] and the Breathe Well Model of Care[9].

Exhibit 3: Operational action to manage workforce challenges.

This section focusses on the actions the Health Board is taking to manage workforce challenges. Overall, we found that **the Health Board is improving its workforce planning capacity and capability to focus on its significant challenges, however considerable risks related to vacancies remain, resulting in high use of agency staff.**

What we looked at	What we found
We considered whether the Health Board has identified sufficient resources to support workforce planning over the short, medium, and long-term. We expected to see: • Clear roles and responsibilities for workforce planning. • Appropriately skilled staff to ensure robust workforce planning.	We found that **the Health Board is addressing the fragility of its Workforce and Organisational Development Directorate by strengthening the directorate's operating model and enabling operational service leads to take ownership of their workforce planning.** Corporately, roles and responsibilities for workforce planning are clear within the Workforce and OD Directorate. Led by the Interim Executive Director of Workforce and OD, the directorate has six teams covering: business partnering, operations, clinical education, organisational development, partnership, and occupational health. The Health Board does not have a team of dedicated workforce planners, but the Head of Workforce Transformation, Planning and Resourcing's role involves strategic workforce planning. In addition, the business partners support operational

[8] The North Powys Wellbeing Programme was initiated prior to the COVID-19 pandemic, to accelerate the transformation needed to deliver against the shared long-term Health and Care Strategy, 'A Healthy Caring Powys'.

[9] The Breathe Well Model of Care seeks to enable the completion of clinically appropriate, safe repatriation of respiratory patients from neighbouring health boards and English NHS Trusts.

What we looked at	What we found
• Sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan. • Sufficient financial resources to deliver the workforce strategy or plan.	directorates and divisions develop workforce plans, but this is on top of dealing with operational HR matters. This model limits the amount of time the business partners can dedicate to supporting workforce planning. Additionally, the Workforce and OD Directorate has a high turnover rate[10] and a high proportion of staff on fixed term contracts. These capacity issues jeopardise the Health Board's ability to support workforce planning, potentially risking its ability to achieving the workforce ambitions set out in the Joint Framework and Integrated Plan. To address these challenges, the Workforce and OD Directorate is currently implementing a new operating model. The new model aims to retain staff by ensuring they are working at the top of their profession and skills, which in turn will make them feel more valued. It also aims to free up business partner capacity to allow them to concentrate on supporting directorates on strategic workforce planning. Whilst this is a positive development, the new operating model will take time to embed and will need to be evaluated (see below). Its success is also dependent on service managers supporting the new model by being clear about, and prioritising the professional workforce planning support they request from the team and by taking greater ownership for workforce planning within their services. We met with a selection of service leads as part of this audit. Most participants understood their role in workforce planning but highlighted that operational service pressures left little time to lead on workforce planning in their service. Some participants felt workforce planning was the responsibility of the Workforce and OD Directorate, whilst others raised the need for more trained, dedicated workforce planners across the organisation. The new operating model should go some way to ensuring the Workforce and OD Directorate is appropriately supporting strategic workforce planning, but it does not have the capacity, nor is it the role of the team, to develop workforce plans for operational directorates. As such, the Health Board is strengthening its workforce planning capability by offering online and in person training to operational staff, which is aligned with HEIW's six-step model[11]. The training is targeted at senior leaders and those responsible for workforce planning for their service areas and the Health Board has made good progress at rolling out the training. As at November 2023, 47 members of staff had received the training with a further 20 booked to attend the training during the remainer of 2023-24. As well as strengthening workforce planning capability,

[10] In October 2023, the rolling turnover rate for the Workforce and OD Directorate was 23%.

[11] Health Education and Improvement Wales has developed a workforce planning toolkit based on the following six steps: 1, Define your plan, 2. Map the service change, 3. Define the workforce, 4. Workforce supply, 5. Define actions required, 6 Implement and monitor.

What we looked at	What we found
	the Workforce and OD Directorate is also using the training to clarify corporate and operational workforce planning roles and responsibilities. The Health Board should evaluate whether the roll out of workforce planning training is achieving its intended purpose and strengthening service level workforce planning (**Recommendation 2**). The Health Board's Workforce Futures actions are costed as part of its annual Integrated Plan. Some cross cutting, regional workforce initiatives such as delivering leadership training is funded through the Regional Integrated Fund. The Health Board has a budgeted establishment and reported that it can afford to recruit to all its vacancies. It does not hold vacancies to make cost savings, which is appropriate given the reliance on high-cost agency staffing. Like other bodies, the Health Board is working in a challenging financial environment. However, the Health Board has prioritised investing in workforce initiatives such as its Aspiring Nurse Programme and recruitment of international nurses and doctors to help create a more sustainable workforce.
We considered whether the Health Board has a good understanding of the short- and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • A good understanding of the barriers that might prevent delivery of the workforce strategy or plan. • Plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions. • Clearly documented workforce risks that are managed at the appropriate level.	We found that **the Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date.** The Health Board's workforce ambitions are clearly articulated, but there are a range of risks which may prevent its delivery. These relate to workforce shortages across clinical and non-clinical professions, an aging workforce, recruitment, and retention challenges, coupled with financial pressures. The workforce challenges ultimately increase the Health Board's risks particularly in relation to its ability to deliver safe, high-quality services. Whilst the Health Board has a robust understanding of its workforce risks, which are appropriately managed, the scale of the workforce challenges means that actions to date are having minimal effect on reducing workforce risks. Corporately, workforce risks are appropriately reflected through the corporate risk register. The Health Board has one overarching corporate risk related to workforce[12], which the Workforce and

[12] The corporate workforce risk is: 'failure to plan for, recruit and retain an appropriate workforce results in an inability to sustain high quality services'.

What we looked at	What we found
	Culture Committee is responsible for overseeing. The committee routinely reviews this high scoring risk, scrutinising mitigating actions. These include strengthening workforce planning through training, increasing the number of Bank staff, international nurse recruitment and training new nurses through the Aspiring Nurse Programme. Executive leads also review this risk through directorate performance review meetings and Executive Committee meetings. The Health Board had established a Workforce Steering Group to focus on workforce issues and risks. However, the group, which is a sub-committee of the Executive Committee, has been temporarily stood down to accommodate planning related to the financial challenges. The Workforce and OD Directorate has a separate risk register which is routinely discussed by its senior management team and at executive level performance reviews.
We considered whether the Health Board is effectively addressing its current workforce challenges. We expected to see: • Effective reporting and management of staff vacancies. • Action to improve staff retention. • Efficient recruitment practices. • Commissioning of health education and training which is based on true workforce need. • Evidence that the organisation is modernising its workforce to help meet current and future needs.	We found that **despite the Health Board's proactivity, there remains significant recruitment, retention, and education commissioning challenges, which is resulting in high reliance on agency staff.** The Health Board is experiencing significant challenges with staff retention. It has the highest staff turnover (**Exhibit 9**), compared with other health bodies in Wales, with most staff leaving because their fixed term contract has ended (25%) or resignation due to relocation (25%). However, a considerable proportion leave without giving a specific reason (27% 'other'). This means the Health Board does not fully understand why staff are leaving, and as such managers are being encouraged to conduct exit interviews. In addition, HEIW is developing a stay interview. Once developed, the Health Board plans to use this to complement exit interviews. The Health Board recognises its retention challenges and is recruiting a Band 8a post in early 2024 to focus solely on staff retention. This is a positive development and a good opportunity for the Health Board to bring together retention initiatives into a consolidated programme with a greater focus on impact (**Recommendation 3**). Current retention activities include a range of staff wellbeing activities, such as road shows and workshops on positive psychology and resilience. The Workforce and OD Directorate is developing good practice guides for managers to improve retention, it offers a leadership and management programme and conducts 'Team Climate' surveys to identify actions to support retention. The Health Board also has a Staff Experience and Wellbeing Manager.

What we looked at	What we found
	In June 2023, the Health Board's vacancy rate was 11.7% (**Exhibit 10**), with nursing and midwifery holding the greatest vacancies. Its sickness absence rate was 5.2% (**Exhibit 11**). Unsurprisingly, to manage short-term workforce shortages, the Health Board has increased its agency use, especially since 2020-21 (**Exhibit 8**). Whilst the current forecast is that agency spend is expected to reduce to around £8.6 million in 2023-24, agency costs would still represent approximately 11% of the Health Board's total pay expenditure. This approach is not sustainable, and as a result the Health Board has developed a variable pay reduction action plan to help tackle the issue. The plan includes actions such as encouraging the use of, and increasing the number of, bank staff, introducing a system which facilitates more frequent payment for bank staff, improving the flexibility of rotas and holding and attending recruitment events. The Health Board also runs an international nurse recruitment programme, which successfully recruits small cohorts of nurses about three times a year. The Health Board is unable to facilitate a large group of international nurses because its community hospitals are geographically spread with limited resources to support training and mentorship. There are also challenges in finding suitable accommodation. To improve the situation, for the February 2024 cohort, the Health Board is planning a shorter training period and a slight increase in recruits (from four to six). To alleviate the accommodation issues, the Health Board is developing its own accommodation, within the Health Board estate. Given the Health Board's recruitment challenges, it needs to have effective recruitment practices. The Health Board is monitoring all roles on its TRAC recruitment system with a view to improving the time to hire, and monitoring bank staff applications weekly to ensure a quick recruitment process. The Health Board is also mapping its recruitment process from application stage to appointment with a view to identifying where the process needs improvement. There are weaknesses in the education commissioning process that means that the pipeline of newly qualified staff does not meet the Health Board's demand. This is especially true for nursing. The Health Board appoints significantly less staff than it trains through the commissioning process. For example, in 2022, of the 159 nursing training places commissioned, only 9 (5.6%) ended up working for the Health Board. Additionally, recruitment drives are not successful, between October 2021 and October 2022, only 10% of nursing and midwifery (band 6-8) vacancies were filled, this equates to just 22 of the 216 vacancies. The Health Board's 10-year projection data shows that this trend is set to continue. This and the lack of universities in the region has prompted the Health Board to seek alternative solutions to build a sustainable workforce. Branded under Powys's Health

What we looked at	What we found
	and Care Academy[13], the Health Board is heavily focused on growing its own workforce which include programmes such as its aspiring nurse, physiotherapist, and occupational therapist training programmes, as well as its apprenticeship, volunteering, and schools' programmes. This work is starting to have a positive impact, especially the aspiring nurses programme which is currently supporting 70 members of staff through various levels of education, with a further 17 studying for the equivalent of a first-year nursing degree programme. Additionally, in September 2023, the Health Board recruited 22 external candidates to its Adult and Mental Health wards who will be supported through the programme. HEIW recognises that the traditional commissioning route is not working for the Health Board. As a result, they have started to fund its Aspiring Nurse Programme and are working with the Health Board to develop more flexible routes into nursing and healthcare support work, for example through dispersed and distance learning. It is also exploring the use of newer roles such as physicians' associates and advanced practitioners, but progress is yet limited.

Exhibit 4: Monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **there is effective oversight of workforce performance and the Workforce Futures Programme, however, the Health Board needs to better understand whether its actions are making a difference.**

What we looked at	What we found
We considered whether delivery of the Health Board workforce strategy or plan is supported	We found that **the Workforce and Culture Committee receives comprehensive workforce performance information and has good oversight of the Workforce Futures Programme, but**

[13] The Powys Health and Care Academy is the regions programme of health and care training, development, and research. The academy is organised about four conceptual schools, these being the schools of 'Professional and Clinical Education and Training', 'Research, Development and Innovation', 'Leadership', and 'Volunteers and Carers'.

What we looked at	What we found
by robust monitoring, oversight, and review. We expected to see: • Arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels. • Effective action where progress on elements of the workforce strategy or plan are off-track. • Performance reports showing the impact of delivering the workforce strategy or plan. • The organisation benchmarking its workforce performance with similar organisations.	**there is a need to better understand the impact of its delivery, and opportunities to benchmark with similar organisations.** The Workforce and Culture Committee is responsible for scrutinising workforce matters which includes delivery of the Health Board's part of the Joint Framework. As stated on **page 10,** there is no standalone implementation plan, instead the Health Board's actions are included within its Integrated Plan. The committee receives a progress report against two of the four Workforce Futures strategic priorities, at each quarterly meeting. The updates are narrative based, and while comprehensive, they are not sufficiently clear on progress against key actions and milestones (**Recommendation 4**). Although, the quarterly Board Integrated Plan progress report clearly sets out the key actions as detailed in the Integrated Plan, progress against each milestone[14] and an assessment against year-end delivery. The report clearly highlights where and why delivery is off-track and what action will be taken to ensure progress. The 2023-24 quarter two report reported that 2% of the Workforce Futures actions were complete, 25% on track, 9% at risk or behind schedule and the rest not yet due. The quarter two report indicates that the Health Board has a high-level of confidence that it will deliver most Workforce Futures milestones by year-end. However, following an Integrated Plan partial reset exercise, some actions will be reprioritised to help the Health Board to meet its financial savings targets. At each meeting, the Workforce and Culture Committee also receives an overview report from the Director of Workforce and OD and a Workforce Performance Report. The Workforce Performance Report gives a good overview of key workforce metrics such as staff in post, appraisal and mandatory training compliance, staff absence, turnover, variable pay and employee relations. Encouragingly, for each area of performance, the report highlights areas of concern and mitigating actions. However, while these reports clearly show progress on key actions and highlight key issues, there is currently insufficient analysis on whether the actions are having the desired impact. For example, whether key workforce metrics have changed, or risks have reduced because of delivering Workforce Futures actions (**Recommendation 4**).

[14] The Health Board uses a Blue, Red, Amber, Green (BRAG) system to track progress, respectively meaning complete, behind schedule, at risk and on track.

What we looked at	What we found
	The Health Board reported that where possible, it benchmarks its workforce performance with other health bodies in Wales. However, given the differing population and geography, like for like comparison within Wales is difficult. However, there is an opportunity for the Health Board to identify similar organisations across the UK to benchmark its workforce performance and identify good practice and innovation (**Recommendation 5**).

Appendix 1

Audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

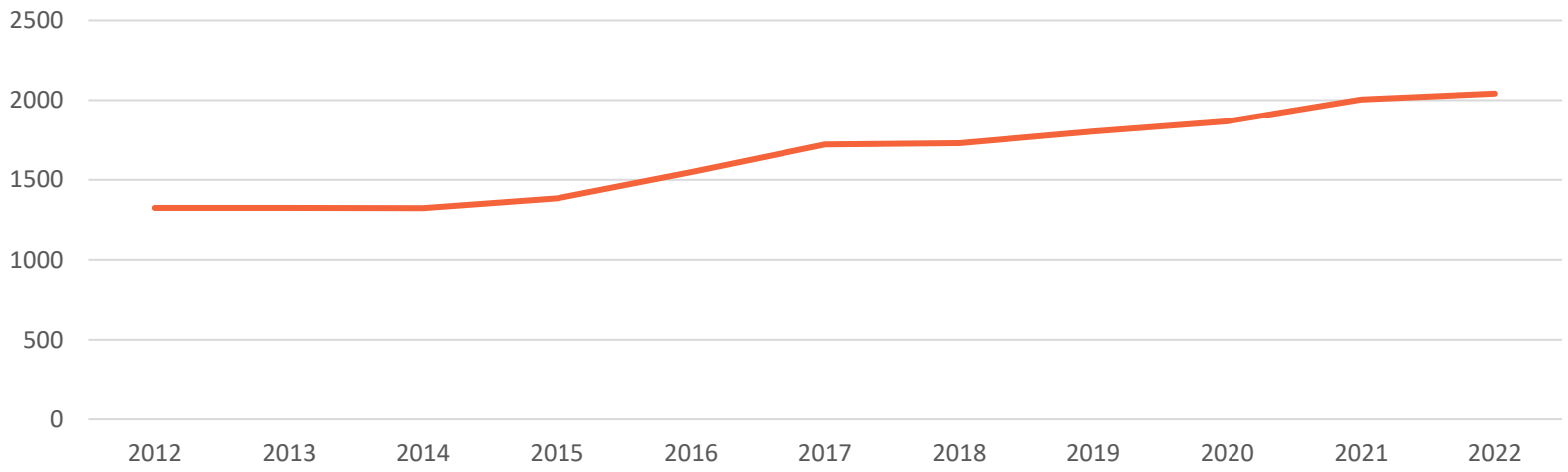
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s) • Implementation / delivery plans for workforce strategy – high-level and operational • Evidence of evaluation of workforce strategy and/or associated initiatives • Information feeding into workforce strategy development e.g., needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning. • Evidence of stakeholder engagement. • Structure charts for workforce planning functions. • Examples of workforce planning training offered to staff e.g., CIPD, other training formal or informal. • Workforce finance and resource plans • Corporate and operational risk registers • Document showing recruitment process and recruitment and retention initiatives. • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery

Element of audit approach	Description
Interviews	We interviewed the following: • Executive Director for Workforce and Organisational Development • Deputy Director for Workforce and Organisational Development • Assistant Director of People Development • Assistant Director of Finance • Head of Organisational Design & Workforce Transformation • Business Partners
Focus groups	We ran two focus groups with: • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services.

Appendix 2

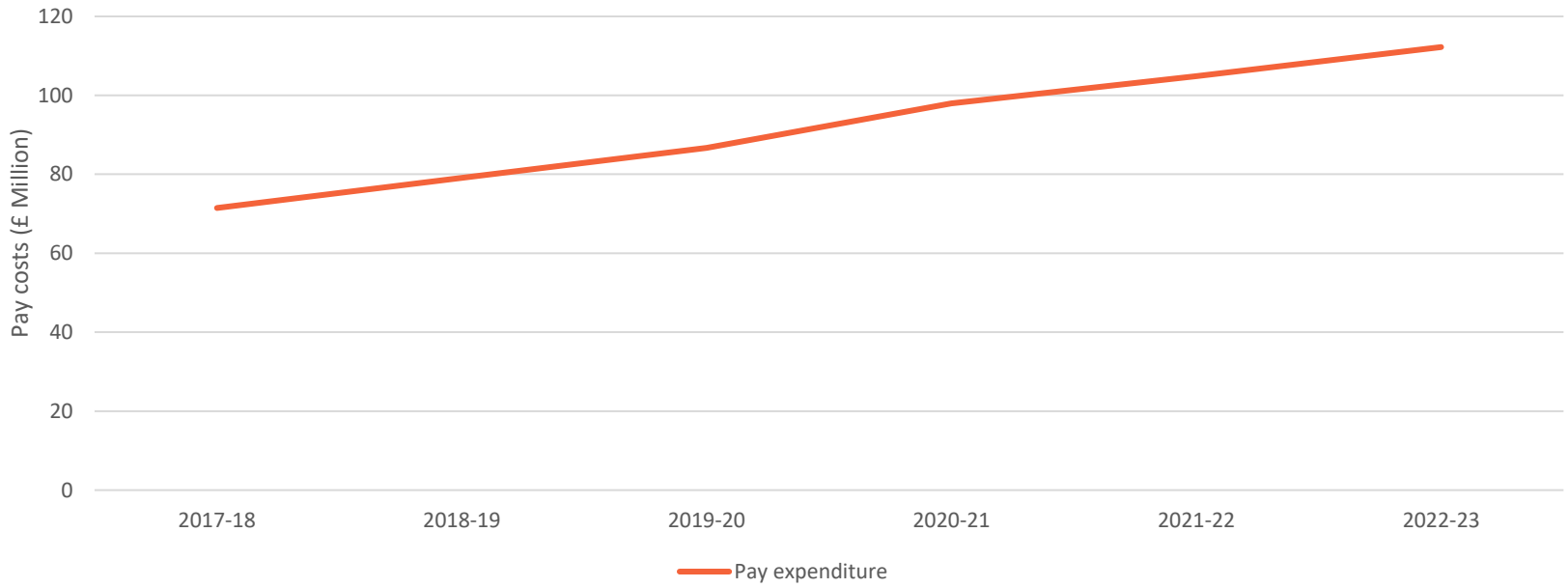
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full time equivalent), Powys Teaching Health Board



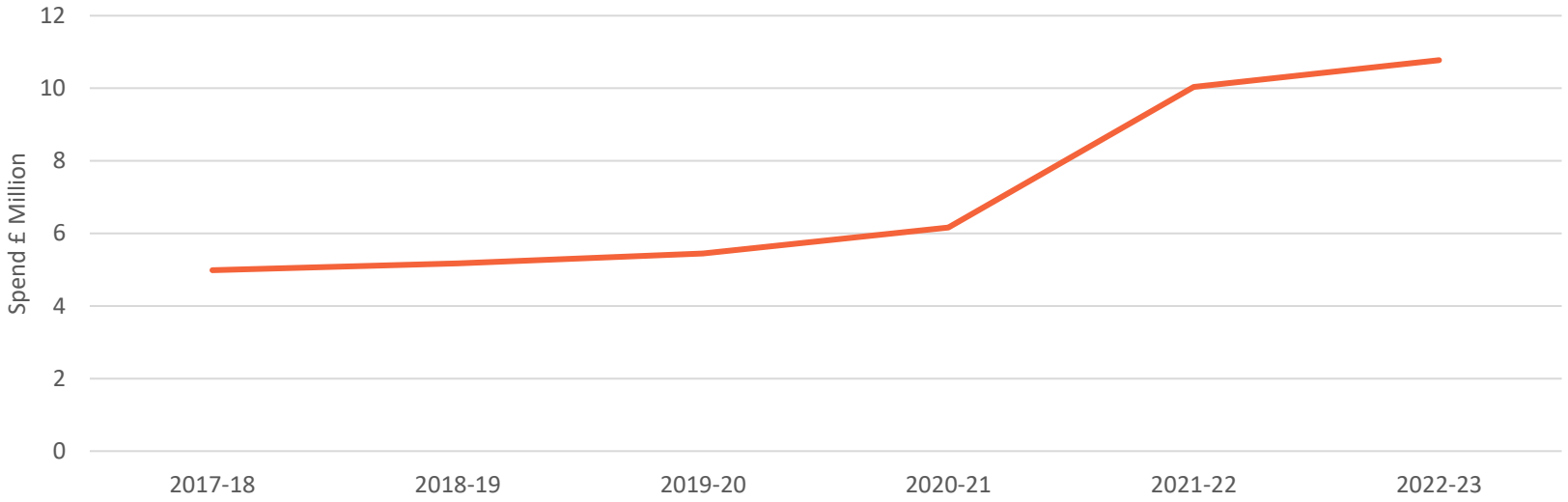
Source: Welsh Government, Stats Wales, Data as of September each year.

Exhibit 7: trend in actual workforce costs, Powys Teaching Health Board



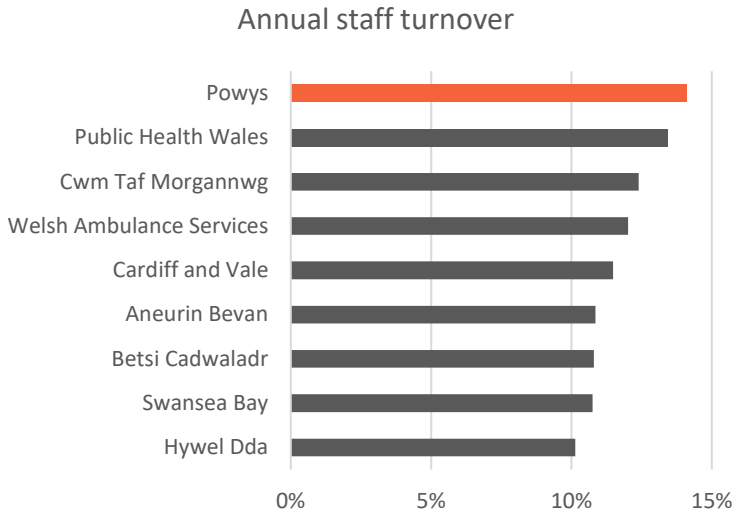
Source: Monthly Monitoring Returns reported to Welsh Government

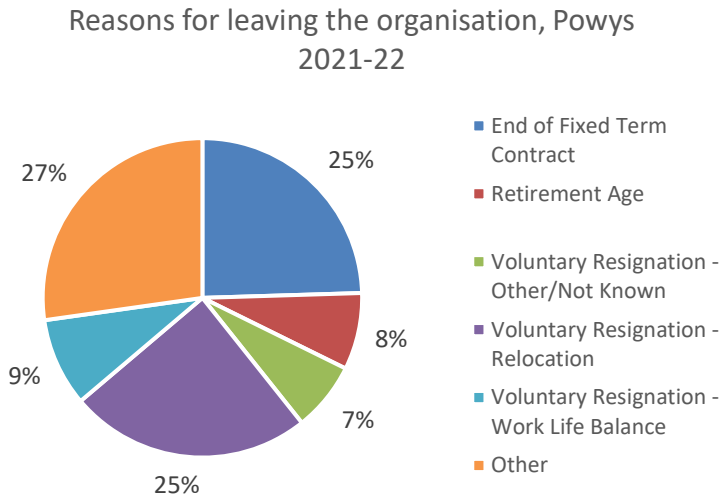
Exhibit 8: trend of expenditure on workforce agency £ million, Powys Teaching Health Board



Source: Monthly Monitoring Returns reported to Welsh Government

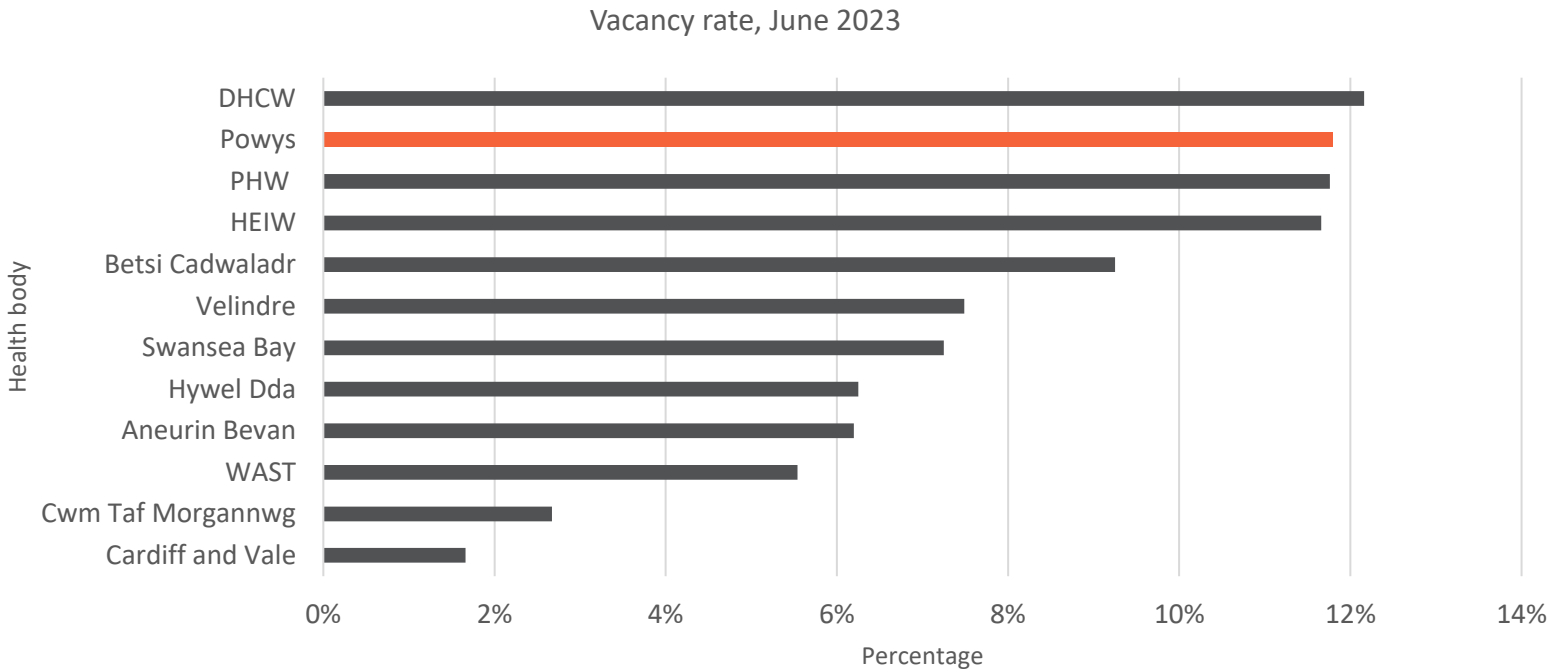
Exhibit 9: Annual staff turnover and reason for leaving, 2021-22, Powys Teaching Health Board





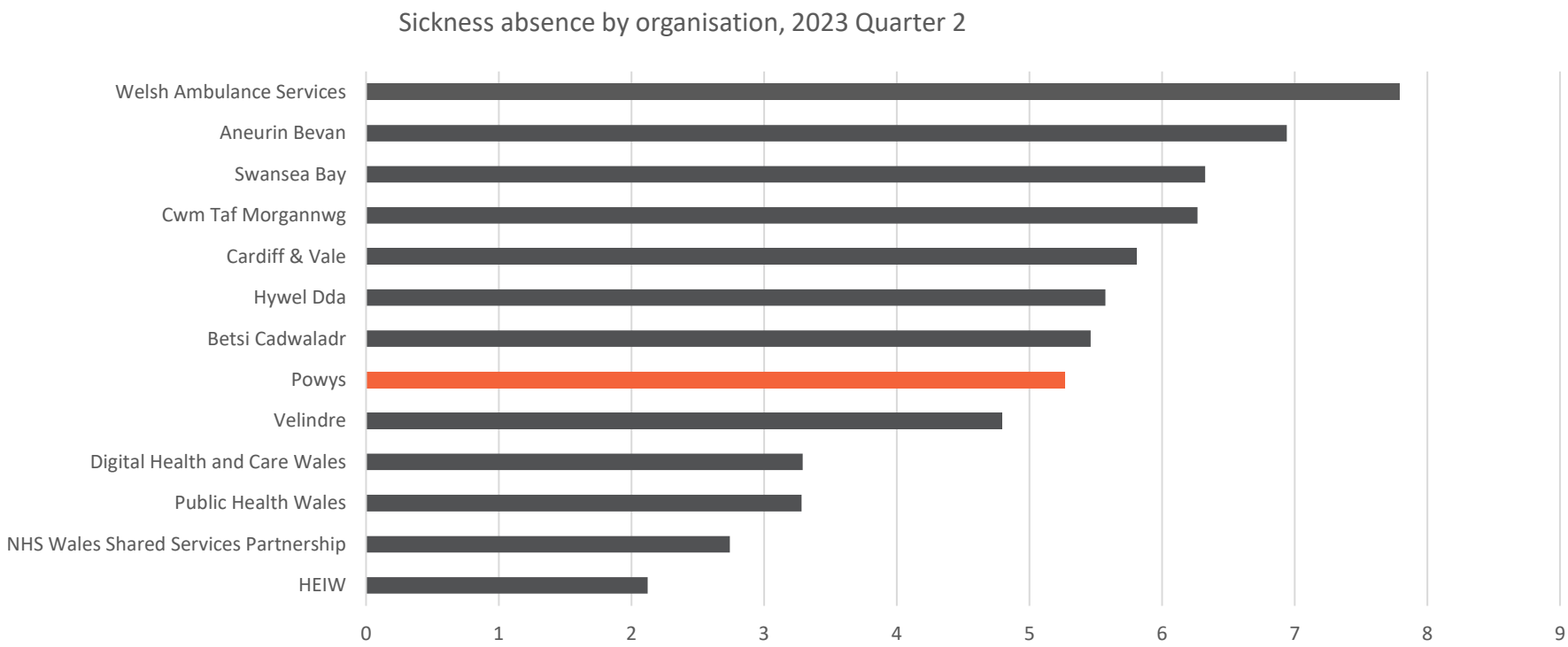
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancy rate, June 2023



Source: Welsh Government, Stats Wales

Exhibit 11: sickness absence by organisation by percentage, 2023 Quarter 2



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Powys Teaching Health Board's response to our audit recommendations.

Ref	Recommendation	Organisational 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	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 (**see page 11**).	We will: • 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.	Q4 2024-25	Deputy Director WOD

		• Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.		
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 (**see page 15**).	We will: • 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.	Q4 2024-25	Deputy Director WOD
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 (**see page 16**).	• 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

		include analysis from staff exit questionnaires.		
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 (**see page 19**).	We will: • 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.	Q1-4 2024-25	Deputy Director WOD
R5	The Health Board should identify organisations across the UK with similar workforce challenges to benchmark its workforce performance and share good practice (**see page 20**).	We will: • Work with the Health Boards Corporate Performance Team to try to identify similar organisations whose workforce metrics can be accessed in order to benchmark.	Q4 2024-25	Deputy Director WOD

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Taxiphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Powys Teaching Health Board

Audit year: 2022-23

Date issued: February 2024

Document reference: 4076A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

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

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

Contents

Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Powys Teaching Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts.
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible using technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 27 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges

that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Interim Chief Executive, Director of Finance and Director of Corporate Governance have agreed the factual accuracy of this report. We presented it to the Audit, Risk and Assurance Committee on [date]. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I issued an unqualified true and fair audit opinion on your accounts on 27 July 2023. The audit opinion in respect of the regularity of expenditure was qualified because the Health Board breached its resource limit by spending £6.8 million over the £1,133 million that it was authorised to spend in the three-year period 2020-23.

13 My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit Committee for improvement.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

14 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There's a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.
- Despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Health Board is taking appropriate action to address its significant workforce challenges, with good oversight of its Workforce Futures ambitions. However, there are opportunities to strengthen the Workforce Futures implementation plan and focus more on the impact of actions that the Health Board is taking to reduce its workforce risks.
- The Health Board has generally effective arrangements to ensure good governance which have strengthened since our last review. However, opportunities exist to improve these arrangements further with a particular focus needed on public access to policies, increasing a focus on primary care, hearing from patients and developing the Board Assurance Framework.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

20 I issued an unqualified true and fair audit opinion on your accounts on 27 July 2023. The audit opinion in respect of the regularity of expenditure was qualified because the Health Board breached its resource limit by spending £6.8 million over the £1,133 million that it was authorised to spend in the three-year period 2020-23.

21 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My audit team reported these issues on 21 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	The Health Board chose not to correct for several issues identified from our audit of payables and post year end payments (see other significant issues below). The cumulative value of these errors is not material.
Corrected misstatements	There were initially other misstatements in the accounts that were corrected by management, and we brought the more significant of these to the attention of the Audit Committee in our report.

Issue	Auditors' comments
Other significant issues	Our initial testing of **Payables and Post Year End Payments** both identified initial misstatements. **Payables (Note 18 - £44.2 million)** We tested an initial sample of £10.3 million (29 sample items), and found 8 errors of classification of £1.6 million, but also an overstatement of £119k. As a result of these findings the Health Board undertook its own review of this balance and identified a further misclassification of £740k. Our additional sample of £8million (10 items), identified no further errors. **Post Year End Payments** Our initial sample of £10.2 million (22 payments) identified 2 misstatements. 1 overstatement of £15k and 1 understatement of £ 93k. Our additional sample of £2 million (10 payments) identified no further errors. Whilst we were satisfied the balances were materially correct, we made a recommendation for improvement in this area which was accepted by management.

22 My separate audit of the charitable funds accounts is ongoing. I anticipate issuing my opinion in January 2024.

Regularity of financial transactions

23 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

24 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

25 The audit opinion in respect of the regularity of expenditure was qualified because the Health Board breached its resource limit by spending £6.8 million over the £1.133 million that it was authorised to spend in the three-year period 2020-23.

26 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the issue set out above, I issued a substantive report setting out the factual details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

27 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- commenting on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments.
- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally.
- reviewing the effectiveness of the Health Board's workforce planning arrangements.
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

28 My conclusions based on this work are set out below.

Orthopaedic Services in Wales

29 In March 2023, I commented on orthopaedic services across Wales. My national report 'Orthopaedic Services in Wales – Tackling the Waiting List Backlog' sets out the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the nationally co-ordinated work to modernise services. My report also set out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services.

30 My work found that securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with the COVID-19 pandemic making this significantly worse. Previous monies allocated by Welsh Government have resulted in short term improvements but have not achieved the sustainable changes to services that were necessary with orthopaedic waiting list targets not met since they were first established in 2009.

31 Since the impact of the pandemic has lessened, orthopaedic services have been slow to restart, and while necessary infection control regimes will continue to have an impact on throughput, there is scope for current capacity to be used more

efficiently. My scenario modelling indicates that it could take between three to five years to return orthopaedic waits to pre-pandemic levels across Wales. This is based on both a significant drive on community-based prevention and an increase in capacity and activity. Without this, services may never return to pre-pandemic levels.

32 My work found that there is a clear commitment to improve orthopaedic services. NHS Wales commissioned efficiency and effectiveness reviews both nationally and locally, which set out a suite of recommendations. A national clinical strategy for orthopaedics was also commissioned which sets out service options and a clear clinical voice on what needs to be done. However, urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

33 In addition to my national report, my team set out how the Health Board's orthopaedic services compare to other health boards across Wales. My comparative report highlighted that the Health Board has:

- the lowest waits in Wales, including patients waiting longer than a year for a first outpatient appointment, and the second lowest proportion of patients on the waiting list for longer than two years;
- the lowest level of potential latent 'lost' demand as an impact of patients not going to their GP during the pandemic;
- higher than average waits for radiology services and physiotherapy; and
- good uptake of 'see on symptom' pathways to reduce unnecessary follow-up outpatient demand.

34 My scenario modelling indicates that optimistically the waiting list for the Health Board could return to pre-pandemic levels by 2026, but without concerted effort may take many years to return to pre-pandemic levels, if at all.

35 My local report sets out a series of prompts and questions for Board members to inform debate and obtain assurance that improvement actions at a local level are having the desired effect.

NHS workforce data briefing

36 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

37 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

38 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies can recruit sufficient graduates once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer. The data briefing provides context for the local review of workforce planning my team are currently undertaking at the Health Board.

Workforce planning

39 My review examined whether the Health Board has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

40 My work found that the Health Board is taking appropriate action to address its significant workforce challenges, with good oversight of its Workforce Futures ambitions. However, there are opportunities to strengthen the Workforce Futures implementation plan and focus more on the impact of actions that the Health Board is taking to reduce its workforce risks.

41 The Health Board is facing significant workforce challenges owing to its rurality and large geographic footprint, which is further compounded by poor public transport, and a limited supply of qualified staff because the region is sparsely populated, has an aging population, and does not have a university. Despite the Health Board steadily increasing its workforce over the last decade, staff retention is an issue. The Health Board has the highest rate of staff turnover (15%) and one of the highest rates of vacancies (11.7%) in Wales. Agency spend increased to £10.7 million in 2022-23.

42 The Health Board is working proactively with its regional partners to collaboratively address current and future workforce challenges and it has a good understanding of current demand with forecasts based on current service models. Whilst there is an implementation plan to support delivery of its Workforce Futures ambitions, there is scope to have a greater focus on impact, and the Health Board needs a greater understanding of the future shape of services.

43 The Health Board is addressing the fragility of its Workforce and Organisational Development Directorate by strengthening the directorate's operating model and enabling operational service leads to take ownership of their workforce planning. The Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date. Despite the Health Board's proactivity, there remains significant recruitment, retention, and education commissioning challenges, which is resulting in high reliance on agency staff.

44 The Workforce and Culture Committee receives comprehensive workforce performance information and has good oversight of the Workforce Futures Programme, but there is a need to better understand the impact of its delivery, and opportunities to benchmark with similar organisations.

Structured assessment

45 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

46 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

Board transparency, effectiveness, and cohesion

47 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- public transparency of Board business;
- arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

48 My work found that the Board and Committees generally operate well, there is commitment to improved cohesiveness and transparency but public access to some key documents continues to need improvement. Board and committee papers are generally good quality, with increasing use of data and graphics but oversight of primary care needs strengthening and more could be done to get a broader spectrum of patient experience.

49 The Board remains committed to conducting its business openly and transparently, with opportunities to enhance arrangements further. The Health Board makes good use of its website, but more can be done to ensure social media and other communication routes are used effectively to promote and encourage engagement in Board business. It would also be beneficial to have unconfirmed minutes publicly available soon after meetings, to avoid long waits between committee meetings.

50 There are good arrangements in place for updating and monitoring compliance with core control frameworks, although opportunities remain to increase public accessibility of policies and ensure the Health Board website has the most recent versions of documents uploaded. The Board and committees are operating well with a balanced and appropriate level of scrutiny. Papers are generally of a good standard, with data and graphics increasingly being used to communicate information. However, the Board could benefit from increased oversight of Primary Care to be assured it is focussing on areas which have significant impact on its population.

51 The Board is committed to hearing from patients and staff, but more could be done to get a broader spectrum of feedback. The Board and committees need to hear both positive and negative experiences. While it positive that the Health Board has reintroduced walkarounds, there is scope for the Health Board to formalise this process. The Board is cohesive after a period of flux and demonstrates a positive commitment to continuous improvement, although there remains scope to strengthen committee effectiveness.

Corporate systems of assurance

52 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

53 My work found that the Health Board still does not have an updated Board Assurance Framework, as a result cannot be assured that risks are aligned despite there being risk management arrangements. Updated performance management arrangements make better use of data but updates on the Clinical Quality Framework and recommendation tracking need to be more consistently scrutinised.

54 The Health Board has not yet completed its update to its Board Assurance Framework (BAF) which is the mechanism to bring together all the relevant information on the risks to achieving the organisation's strategic priorities. This is an ongoing gap in governance. The Health Board is making progress and has developed all the relevant components, but this is yet to be developed into the relevant overarching framework. The Health Board needs to complete this activity as soon as possible.

55 There are good risk management arrangements, and a refresh of the corporate risk register has been undertaken. However, the Health Board needs to ensure its transition from holding risk registers on spreadsheets to a specific risk software happens at pace. The Health Board continues to have robust performance

management arrangements and the updated Integrated Performance Report allows for easy identification of challenges and progress.

56 The Health Board has appropriate arrangements in place to oversee implementation of the new duties of candour and quality, and to maintain oversight and scrutiny of quality and safety. But there is a gap in the oversight of the Clinical Quality Framework Implementation Plan which has not been received by the Patient Experience, Quality and Safety Committee for some months. There are also good arrangements for tracking progress against audit recommendations, however a delay in presenting the recommendation tracker to Audit, Risk and Assurance Committee (ARAC) has meant that this committee has not been fully sighted of progress in implementing audit recommendations.

Corporate approach to planning

57 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
- overseeing the delivery of corporate strategies and plans.

58 My work found that while the Health Board's corporate planning arrangements are good, it has been unable to produce an approvable IMTP.

59 The Health Board has strengthened its approach to developing its plans. The 10-year strategy continues to be in place which has been used to set the framework for the three-year plan. Progress has been made to increase the involvement of Independent Members in the production of plans and strategies, with good use of Board development sessions. However, despite these arrangements, the Health Board has been unable to produce an approvable IMTP for 2023-26. Instead, it has an Integrated Plan for 2023-26 and is working to an Annual Delivery Plan for 2023-24 approved by Welsh Government.

60 The Health Board continues to have good arrangements in place to monitor delivery of its plans and strategies, with the refreshed Integrated Performance Reports provided bi-monthly and the quarterly Integrated Plan Progress Reports providing robust assurance to Board and its committees. Scope continues to exist however for the Health Board to make clearer links between the 'Powys Outcomes' in its three-year plan and measurable impacts in its Annual Delivery Plan.

Corporate approach to managing financial resources

61 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;

- overseeing financial management; and
- overseeing financial performance.

62 My work found that although the Health Board has robust arrangements in place for managing and monitoring its finances, its financial position is increasingly challenging.

63 The Health Board did not meet its revenue financial duties for 2022-23 and is predicting to not meet them again in 2023-24. Working to a revised deficit control total of £12 million by the end of the year, the Health Board was forecasting it would meet its control target at year-end at Month 10.

64 The Health Board has a robust approach to financial planning, with good engagement with the Board. The Health Board requires a savings target of £7.5 million. At Month 10, the Health Board had identified potential saving schemes totalling £11.5 million, although the recurring impact was forecast to be only £5.8 million.

65 The Health Board has good arrangements for overseeing and scrutinising financial management. Robust arrangements also continue to be in place for monitoring and scrutinising its financial position, with comprehensive reports which allow for easy identification of challenges and risks.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2023.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2023
Opinion on the Financial Statements	July 2023
Opinion on Charitable Funds Financial Statements	January 2024 (tbc)
Performance audit reports	
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog: A comparative picture for Powys Teaching Health Board	March 2023
NHS Workforce Data Briefing	September 2023
Review of Workforce Planning Arrangements	February 2024
Structured Assessment 2023	February 2024

Report	Date
Other	
2023 Audit Plan	May 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Primary Care Follow-up Review	March 2024
Unscheduled Care: Flow out of Hospital – Powys Region	March 2024
Discharge Planning: Progress Update	March 2024
Review of Financial Efficiencies	March 2024
Unscheduled Care: Arrangements for Managing Access	July 2024
Review of Planned Care Services Recovery	September 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £301,850 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • evaluate the rationale for any significant transactions outside the normal course of business.	Having undertaken the proposed audit work, we found no significant issues.
There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 12 shows a forecast year-end deficit of £7.5 million. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.	We will focus our testing on areas of the financial statements which could contain reporting bias.	Our testing did not identify any reporting bias.

Audit risk	Proposed audit response	Work done and outcome
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert. • test the appropriateness of asset valuation bases. • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts. • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	No material issues were found.
There is a risk that the Health Board fails to disclose certain related party transactions and disclosures or discloses these transactions at the incorrect value.	We will review the completeness and accuracy of the disclosures.	Our audit work identified two organisations which had been correctly disclosed by two individuals on their Declaration of Interest form, but which had been incorrectly excluded from the note to accounts. We also identified input error between transactions and balances included for organisations within the

Audit risk	Proposed audit response	Work done and outcome
		relate party note, and the transactions and balances included within the ledger. All issues were amended prior to the accounts being signed.
There have been historic errors in the Health Board's draft financial statements, when disclosing Senior Officers and Non-Executives Pay within the Remuneration Report.	We will review the completeness and accuracy of the disclosures	Our audit identified several amendments relating to senior officer remuneration, to ensure that disclosures complied with the requirements of the underlying accounting framework.

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Agenda Item: 3.4

Audit, Risk and Assurance Committee	DATE OF MEETING: 11 March 2024
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and presented by:	Director of Corporate Governance/ Board Secretary
Prepared by:	Interim Corporate Governance Business Officer
Other Committees and meetings considered at:	N/A

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 January 2024.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **CONSIDER** the current position of outstanding Audit Recommendations and take **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

BACKGROUND AND ASSESSMENT:

INTERNAL AUDIT

The reporting period 2019/20, 2020/21, 2021/22, 2022/23 and 2023/24 is summarised by Internal Audit priority level (high, medium**,** and low). This approach is being taken for all new audit recommendations received going forward.

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

Covid-19 Prioritisation	2019/20	Internal Audit Priority	2020/21	2021/22	2022/23	2023/24	TOTAL OUTSTANDING
	Number		Number				Number
Priority 1	1	High	1	2	5	7	16
Priority 2	4	Medium	1	3	10	9	27
Priority 3	0	Low	0		4	7	11
Not Yet Prioritised	0						0
TOTAL	5		2	5	19	23	54

Details of internal audit recommendations can be found appended to this report as follows: -
Appendix 1 – Internal Audit Recommendations that remain OUTSTANDING.
Appendix 2 – Internal Audit Recommendations COMPLETED since the previous report.
Appendix 3 –Internal Audit Recommendations NOT YET DUE for implementation.

EXTERNAL AUDIT

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

Overdue External Audit Recommendations						
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/2024**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Priority 1	0	0	0	0	0	0
Priority 2	0	0	0	0	0	0
Priority 3	0	0	0	0	0	0
Not Yet Prioritised	0	0	0	4	0	4
TOTAL	**0**	**0**	**0**	**4**	**0**	**4**

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix 4 – External Audit Recommendations that remain OUTSTANDING.
External Audit Recommendations Not Yet Due for Implementation (NB. None in this category)
Appendix 5 – External Audit Recommendations COMPLETED since the previous report.

LOCAL COUNTER FRAUD SERVICES

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

NEXT STEPS:

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

APPENDIX 1 - Internal Audit Recommendations OUTSTANDING

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
														Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementation be achieved?					
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	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	Sep-21	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 receveid 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 apart of the D2RA pathway implementation	Sep-21		27	18	Mar-23	
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	Mar-22	Overdue		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 will 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.	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	By March 2024		28	22	Feb-24	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	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		Overdue		Partially 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.	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 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.		5		May-23	
212207	Dementia Services-Home Treatment Teams	Reasonable	Director of Operations	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	3		Feb-24	Jan-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation / Assistant Director of Estates and Facilities	R5	Fire and water detection should be included at both sites. Consideration should be given to providing a dedicated power supply to the Bronllys room. Fire suppression should be installed at Brecon. The air conditioning within Brecon should be reviewed to ensure it is capable of reducing the temperature appropriately.	Fire detection and suppression are in place at Bronllys, but no water detection. Air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient There are plans to move on premise servers held within the Data Centre to the cloud so this will reduce the risk of on-premises DC's.A plan will be developed with Estates and Facilities to assess the water detection requirements and to test and provide assurance relating to the power requirements (initial meeting already taken place).	Mar-23		Overdue		Partially complete		a full audit has been completed of comms rooms, there will be a report available with requirements to be submitted to estates and facilities 11/04/2023 - No progress 27/11/2023 - This is reliant on working in partnership with Estates and Facilities capacity which is focussing on other digital priorities such as cabling, but ongoing discussions are in place to support this. There are also plans to potentially re-locate data centres if the water detection is not practical.					11	11	Feb-24	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R7	The network should be split into Vlans. The firewalls should be deployed.	Network re-design plane is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	Mar-23		Overdue		Partially complete		The firewalls have been deployed and there is a design plan to segment the network and implement V-Lans 11/04/2023 - New switching and wifi infrastructure procured at the end of 2022/23 FY will allow the design and implementation of segmented vlans. This is a significant activity and may take most of 2023/2024 to implement. 27/11/2023 - The network segmentation re-design is complete, there are technical challenges and some dependances to implement that are being worked through, progress is ongoing					11	11	Feb-24	Sep-22
222317	Cyber Security	Limited	Director of Finance, Information and IT	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.	Apr-23		Overdue		Partially 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.					9	9	Feb-24	Mar-23
222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure and Cyber Security	R3	The data replication process should be re-instated/ replaced as a matter of urgency. Backup files are a critical component in the defence against cyber-attack. They should be at least encrypted, and stored on appropriately secure media, with a remote copy in line with established best practice. Backups require as much security as can be afforded to maximise their protection against compromise through unauthorised network access. Test restorations (a rolling partial programme) should be carried out at least monthly and recorded to confirm their full success. This can often be achieved as part of estate management, server swapping, load balancing etc. All user requested restorations should also be recorded.	Agreed, Actioned and part completed. New Hardware procured to provide air gapped secure back up storage to mitigate the impact of a cyber incident. Procedures are being developed as a priority to demonstrate the consistency of our backup operations on a regular basis.	Apr-23		Overdue		Partially complete		Data replication has been reinstated and some progress has been made in developing a restoration cycle to test backup consistency. New hardware procured will improve the cyber posture by introducing air gapped backup media and storage.					9	9	Feb-24	Mar-23
222328	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	R6	Corporate Governance Department should ensure that ongoing progress is maintained so as to enable completion and sign-off of the Board Assurance Framework by the Board in accordance with the prescribed Risk and Assurance Forward Plan 2023/24 timescale.	The BAF is in development, an initial working copy will be in place Autumn 2023 with a final copy approved for 1 March 2024.	Mar-24		Not yet due		Partially complete		Nov 2023 update - The BAF is in development and on track for the target deadline of 31 March 2024. Feb 2023 - on track for 31 March, update scheduled into ARAC for March 2024 meeting.						#NUM!	Feb-24	

232405	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of 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		Not yet due		Partially complete		This is linked to action 232402 and 232404					2	2	Feb-24	
232406	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Performance and Commissioning	Katie Games/Senior Manager Planned Care	R6	Evidence should be obtained for the Health Board's In-reach Medical Staff relating to Disclosure and Barring Service (DBS) checks, accreditation, registration, validation, job planning and appraisals of all clinicians. The evidence should be reviewed for issues relating to In-reach Medical Staff and appropriate action should be identified and taken.	Within existing SLA documentation there is clear expectation that commissioned service providers provide assurance to PTHB and with evidence to support Disclosure and Barring Service (DBS) checks, accreditation, registration, validation, job planning and appraisals of all clinicians(s). This will continue to be monitored through the CQPRM process with expectation that commissioned service providers inform PTHB of any change in status or concern. Where assurance is not provided, this will be escalated in accordance with the SLA terms and conditions.	Ongoing		Overdue		Partially complete		We have requested that all providers confirm all applicable checks have been made by them as the employing organisation. This continues to be a requirement of the SLA template.					#VALUE!	#VALUE!	Feb-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		Jun-24		#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		Mar-24		#NUM!	#NUM!	Feb-24	Jan-24
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	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.	Process	Completed local review of scheme of delegation and sign off procedures in Dec			#NUM!	#NUM!	Feb-24	Jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	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		Not yet due		Partially 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.					#NUM!	#NUM!	Feb-24	Jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	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 authority 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		Not yet due		Partially 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					0	0	Feb-24	Jan-24
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	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		35	20	Mar-23	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	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	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		36	23	Mar-23	
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 working e.g. digital appointment solutions like Attend Anywhere. The Patient Access Policy will be updated in line with the revised WG guidance once published.	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.	Waiting for overall WG rollout		Jun-23		34	22	Feb-24	Sep-20

192026	Risk Management and Board Assurance	Limited	Director of Corporate Governance/Board Secretary	Board Secretary / Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and, • the relevant committees have regular oversight of the strategic objectives and risks assigned. b. Consider enhancement of the Board Assurance Framework review process by implementing and presenting a detailed BAF report at Board meetings. c. Establish the concept of Local assurance frameworks into the risk management hierarchy and then introduce them as a process documentation and discussion at directorate level.	Agreed	Mar-21	Mar-23	Overdue	2	Partially complete		High level work has been initiated to outline the framework and principles. 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 BAF is a priority for the 2023/24 year. Revised date requested to 31 January 2024. April 2023 - action is on track for March 2024, reports will be provided as the year progresses. Feb 2024 - action is on track for end March 2024. Update due to Audit Committee March 2024.	Lack of organisational capacity and within the corporate governance team	Agendas for all meetings continue to be scrutinised in order to ensure that the Board is receiving appropriate assurance.	Jan-24		12	10	Feb-24	Sep-20
202115	Winter pressures and flow management	Reasonable	Director of Operations	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		Not yet due		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 disharge guidelines have been circulated for comment. The discahrge 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	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		01/02/2024 - Relucant to leave 28/2/24 - Discharge guidance		22		Feb-24	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	Head of Clinical Education / Medical Device & POCT Manager	R5	1. The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 2. The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	1. Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group is scheduled for 8th November, this was delayed at the request of Clinical Education as waiting for new members of the team to commence into post. The aim of the group will be to pilot a process for a small number of devices. Once this is in the place, the same process will be rolled out for all devices and all staff groups. 2. Management will ensure manufacturer's instructions are stored digitally via the Medical Devices Intranet page where applicable. Capacity to undertake this task is limited. Responsibility for this role and timeframe for completion to be identified.	Mar-22		Overdue		Partially complete		Training matrix has been developed and shared with Governance Leads for review. Shared with MD&POCT Group members in October 2022 and agreed at November MD&POCT Group. Comments received and to be added to matrix. 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.	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		14		May-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	Medical Device & POCT Manager	R6	The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (kpi's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (PPM Contracts) • Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The renewal of the main maintenance contract (due 1st April 2022) provides an opportunity to significantly strengthen this area. Standing agenda item will be added to the Medical Devices Group to review contract monitoring and KPI's.	Apr-22		Overdue		Partially complete		Contract monitoring meetings continue with some providers. Temporary additional resource has provided an opportunity to strengthen processes in this area and identify cost savings. Additional resource has also enabled contract monitoring meetings to be reinstated. However, this won't be feasible in the long term without permanent support in this area. November 2023: Significant work has been undertaken in relation to management of key contracts. This was enabled through temporary additional support to the team. It is anticipated this work will continue in order to continue to strengthen the governance around contract monitoring and management. January 2024: Collaborative working with NWSSP Procurement and main contract provider working towards a resolution to elements of contract that are being challenged. Attempts to focus on other contracts but remains a challenge due to capacity.	Resource prevents progress in this area.	Contract monitoring meetings held for some providers.	Without any additional support it is difficult to understand how the health board will be in a position to strengthen contract monitoring processes and therefore obtain assurance on compliance.		13		May-23	
212207	Dementia Services - Home Treatment Teams	Reasonable	Director of Operations	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	3		Feb-24	Jan-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R6	A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network A review and associated upgrade of Wi-Fi provision should be undertaken	Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Mar-23		Overdue		Partially complete		Project manager is in post and working with suppliers on the specificaiton and quality control for cabling requirements 11/04/2023 - Work is ongoing to address the health boards cabling infrastructure, we are currently working with estated to ensure that all contracted work complies with all applicable standards before implementation. 27/11/2023 - The project is maintaining progress, with funding approved from capital control group for significant improvement in day hospital and Llewellyn ward.					11	11	Feb-24	Sep-22
222307	Looked After Children Health Assessments	Substantial	Director of Nursing & Midwifery	Director of Nursing & Midwifery	R1	Management should ensure that Data entry checks are undertaken to ensure that information held within the LAC Spreadsheet is correct and up to date.	Weekly spot checks by Business support manager of the LAC spread sheet in place. Immediate action in progress and already commenced. The LAC Team had identified the LAC Spreadsheet needed to be updated due to the amount of information it was holding and the time involved in updating the data. The process of redesigning a new system that will improve data collection, imit human error and enable a more efficient use of time has already commenced and will be ready for testing January 2023.	Jan-23		Overdue		Partially complete		spot check of current data speadsheet being undertaken weekly. New data collection/storing system built and ready for testing.		weekly spot checks	new data system will be in place March 2023		12	12	Feb-24	Jan-23
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	Associate Director of Capital, Estates and Property	Project Director	R2	a) All project variations should be approved in line with the Standing Orders. b)W here the THB wishes to vary the delegated financial limits contained within the Standing Orders, a project-specific scheme of delegation should be defined and formally approved at an appropriate level for application at future projects. c) Noting timeliness of contract execution is a recurring audit recommendation at the THB, management should develop an acceptable procedure to facilitate the signing of agreements / contract documentation in a complete and timely manner. 2.2) Project Board minutes should clearly record when a decision is made/approval granted.	a) Agreed. b) Project-specific scheme of delegation will be considered / implemented, dependent on value of project, to administer variations whilst still maintaining the governance criteria for overall cost control for future major projects. c) Strengthening of process to ensure timeliness of signing of agreements / contract documentation will include investigation of electronic signatures and possible delegation of authority for signing of construction related contracts. 2.2) Project Board minutes will clearly record decisions made and approvals granted.	Jan-23		Overdue		Partially complete		a) Complete b) This will be implimented on future major schemes discussions are taking place regarding governance arrangements c) To be implimented on future schemes electronic signatures being implimented - to be discussed with Board Secretary d) Complete					4	4	May-23	Jan-23
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		Not yet due		No progress							#NUM!	#NUM!	May-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Associate Director of Capital, Estates and Property	Senior Responsible Officer	R6	The service mapping should be updated to ensure the programme has continuous relevance in providing a clearer picture to services to users, encouraging solidarity of stakeholders especially locals of North Powys accepting change and importantly supporting the required service transformation plan.	A full review of the service mapping has been carried out and updated and aligned to the 5 transformation areas of work.	Jan-23		Overdue		Partially complete		2 workshops have been undertaken in order to review service mapping. The remaining workshops were stood down due to winter pressures, industrial actions preparation and wider assimilation with the Accelerated Sustainability Model work. Further service mapping has occurred to update from 2014 following recommendations as part of the Internal Audit				Jun-23	4	4	May-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Associate Director of Capital, Estates and Property	Senior Responsible Officer	R7	Management should ensure the membership agreement is sorted promptly for the smooth running of the governance framework and the programme as a whole. Management should also encourage key staff to attend their respective programme meetings drawing their attention to the quorate requirement stated in the ToR in the Governance framework.	Majority of work areas have now identified leads from respective organisations who attend Programme Delivery Team on a monthly basis with the exception of the social model for health transformation area.	Jan-23		Overdue		Partially complete		Workstream leads have been identified however some delay in progressing all workstreams for the reasons outlined above				Jun-23	4	4	May-23	Jan-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	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. January 2024: ongoing. National discussion regarding ESR data consistency for T&HS professions which will support this. Outside of local control so will require further deadline revision.					3	3	Feb-24	Mar-23
222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure and Cyber Security	R1	Progress reporting should contain enough granular detail to enable progress achieved to be accurately tracked and accurate quantification of what remains to be achieved; especially as the ultimate goals will always be changing. E.G. out of support software will always decrease/increase as time passes The software tools available should be configured to provide accurate information on activities related to key objectives. onthly KPI should be produced for senior management. They should be detailed enough to identify the ongoing cyber security position and specifically related to the key objectives of the cyber improvement plan.	Agreed and Action This has been an area of ongoing focus, action and improvement. Significant progress has been made in addressing legacy operating systems, patch compliance and coverage against known assets but it is acknowledged that the reporting of this against internal KPI's and industry to support best practice requires further improvements to provide assurance. Work has already started on developing the required reports and rationalising the tooling (Intune, SCCM, Autopatch) used to ultimately deliver more useful and relevant reports and implement the appropriate KPI's to manage this longer term. As evidenced, the data exists and this will be provided specifically in monthly performance reports for senior management, aligned to the Cyber Improvement Plan and related KPI's.	Jun-23		Not yet due		Partially complete		The development of monthly KPI's has begun with an initial focus on Active Directory. Some progress has been made with Backup Reporting but isn't yet something that can be developed into a KPI. The implementation of New Backup Hardware procured at the end of 2022/2023 will allow additional focus on this area of cyber resilience and subsequent assurance reporting.					7	7	Feb-24	Mar-23
222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	R2	The Health Board should implement a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions regulated by the HCPC and other professional bodies.The structure should also include a forum that oversees, advises and coordinates appropriate application of professional accountability and use of professional title for Health Board Therapy and Health Science professionals which are currently in place within the four departments sampled.	Implementation of a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions.	Oct-23		Deadline Revised		Partially complete		Draft framework document complete, circulated for comments to Professional Leads October 2023. To be finalised and approved at next Professional Leads meeting December 2023. Professional Leads forum established and meets bimonthly.					3	3	Feb-24	Mar-23

222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	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.					3	3	Feb-24	Mar-23
222321	Performance Management and Reporting	Substantial	Director of Performance and Commissioning	Chris Moss	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		Not yet due		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.							Feb-24	
222337	Follow Up: Occupational Health Service	Reasonable	Director of Workforce and OD	Sarah Powell	R2	Management should ensure that once enough data has been recorded the KPI's for accessing the Occupational Health Service are reported to the appropriate forums.	The KPIs relating to referral and appointments will be presented in ' dashboard' format and will be included in Workforce performance reports through to Workforce Steering Group/ Executive Committee and OH performance report dashboard into the Health and Safety Group.	Jul-23		Overdue		Partially complete		Data relating to referral and appointments are now presented in ' dashboard' format performance reports into the Health and Safety Group. Data also used in WOD workforce performance reports . Awaiting the implementaion (end Nov) of the new OPASG" OH system to be able to produce detailed KPI reports. UPDATE FEB 24 - OPASG2 now live, awaiting transfer of all files, and new templates to be configured. Estimated ability to report out on KPI data by 1st April							Feb-24	
222338	Follow Up: Occupational Health Service	Reasonable	Director of Workforce and OD	Helen Hine/ Jo Samuel	R3	Management should ensure that once enough data has been recorded the KPI's for accessing the Occupational Health Service are reported to the appropriate forums.	The KPIs relating to OH pre employment checks will be presented in ' dashboard' format and will be included in Workforce performance reports through to Workforce Steering Group/ Executive Committee and OH performance report dashboard into the Health and Safety Group.	Jul-23		Overdue		Partially complete		Data relating to PECS are now presented in ' dashboard' format performance reports into the Health and Safety Group. Data also used in WOD workforce performance reports . Awaiting the implementaion (end Nov) of the new OPASG" OH system to be able to produce detailed KPI reports. UPDATE FEB 24 - OPASG2 now live, awaiting transfer of all files, and new templates to be configured. Estimated ability to report out on KPI data by 1st April							Feb-24	
222339	Follow Up: Occupational Health Service	Reasonable	Director of Workforce and OD	Helen Hine/ Jo Samuel	R4	Management should ensure that once enough data has been recorded for the newly developed KPI's they are added to the Occupational Health reporting dashboard. The dashboard should then be submitted to the appropriate forums for consideration.	The KPIs for Occupational Health will be presented in ' dashboard' format and included in Workforce performance reports through to Workforce Steering Group/ Executive Committee along with reports into the Health and Safety Group.	Jul-23		Overdue		Partially complete		Data relating to OH are now presented in ' dashboard' format performance reports into the Health and Safety Group. Data also used in WOD workforce performance reports . Awaiting the implementaion (end Nov) of the new OPASG" OH system to be able to produce detailed KPI reports. UPDATE FEB 24 - OPASG2 now live, awaiting transfer of all files, and new templates to be configured. Estimated ability to report out on KPI data by 1st April							Feb-24	
232401	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of 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.					3	3	Feb-24	
232402	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of 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.					2	2	Feb-24	
232403	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Performance	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 23/24. The 23/24 SLAs with English providers have been agreed in principle and we are waiting for the organisations to send us the signed versions with the exception of 1 which is fully signed.					5	5	Feb-24	
232404	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Performance	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	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.					5	5	Feb-24	
232408	Clinical Audit	Reasonable	Medical Director	Medical Director	R2	The Health Board should ensure that sufficient resources are available for clinical audits so that the annual Clinical Audit Programme is fully delivered.	The agreed management plan will be shared with colleagues from the operational services to ensure that prioritisation of audits is understood.	Dec-23		Not yet due		Partially complete		Cascaded to clinical and opertaional execs. Evidencing may be difficult but would be evidenced by delivery of the clinical audit plan. Teams asked to reflect back if they do not think they have capacity for clinical audit. Marked as partially complete. Will mark as copmplete at next review if teams have not fed back concerns re capacity.					2	2	Feb-24	Nov-23
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education	R1	Management should update the current Standard Operating Procedure in place to set out the responsibilities for both the Temporary Staffing Unit and Recruiting Managers in identifying staff that are eligible to participate in the HCSW Induction Programme. Management should also consider including within the SOP the process for updating the Induction Tracker to cover the information required and outlining Department responsibilities. Medium Agreed Management Action Target Date	The clinical Education team will revise the SOP to identify the roles and responsibilities of Recruiting Managers and TSU. To include the process for updating the tracker as part of revised SOP.	Dec-23		Overdue		Partially complete		FEB 24- SOP has been revised to define roles and responsibilities . Tracker is updated and Existing quals are to be added to ESR so partially complete.					2	2	Feb-24	Jan-24
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education	R3	Linked to Matter Arising 1, management need to ensure that the process developed includes information to managers to help to aid with the identification of all staff eligible to register/enrol on the HCSW Induction Programme to avoid unnecessary training sessions being scheduled and then ultimately cancelled. Medium Agreed Management Action Target Date	In support of R1 a process flow/criteria will be provided to recruitment managers that identifies those eligible to undertake the HCSW induction programme and how to sign/ book them onto the induction course.	Mar-24		Not yet due		Partially complete		FEB 24 - In conjunction with data / information on process flows from other Health Boards a new internal process flow is being created. On track for completion End March					#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R1	Management should ensure that where policies have been reviewed, the new updated versions are published on the Intranet as soon as possible and the old versions taken off. For those policies that are overdue for review management need to ensure that they are reviewed and updated as soon as practicable.	Management will review the version control of relevant H&S policies and ensure they are updated in a timely manner	Mar-24		Not yet due		Partially complete		All H&S linked policies are being reviewed so they correspond correctly to each other and the revised meeting schedule. This requires a detail reading of the policy, maaking amendments, then they will go back to HSG in March for ratification and then published before April	None		Apr-24		#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		Apr-24		#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R7	Management should consider introducing a standing agenda item for H&S training compliance review at the Health & Safety Group meeting. This will enable the group to review areas of low compliance and agree appropriate actions.	Management will change the standing agenda item to include a dedicated item on H&S training compliance to ensure there is a focus on low compliance and to agree appropriate actions.	Mar-24		Not yet due		Partially complete		Training compliance is now a standing agenda item and also is reported by services as part of the highlight reports	None		Mar-24		#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R8	Management should ensure that for the information reported on statutory and mandatory training compliance that a standard format is agreed so that all departments are reporting the same information and that the reporting period is also the same	Management will introduce a standard format for the reporting of mandatory and statutory training	Mar-24		Not yet due		Partially complete		Work is gongoing to identify which trainig is to be reported on a standard temlate for the group and will be finalised at the March HSG	None		Mar-24		#NUM!	#NUM!	Feb-24	Jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None	0	Mar-24		#NUM!	#NUM!	Feb-24	Jan-24
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	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							0	0	Feb-24	Jan-24
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	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					#NUM!	#NUM!	Feb-24	Jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	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 bi annually, to discuss progress the Information Asset Register agenda and promotion of good Information Governance practices across the organisation.	Mar-24		Not yet due		Partially 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					#NUM!	#NUM!	Feb-24	Jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	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		Not yet due		Partially complete		see entry above					#NUM!	#NUM!	Feb-24	Jan-24

APPENDIX 2 - Internal Audit Recommendations COMPLETED since last report

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	How is the risk identified being	When will implementation be	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
212206	Theatres Utilisation	Reasonable	Director of Operations	Medical Director	R1	Further work should be undertaken to take forward the consideration regarding appointment of a part time Clinical Director for Endoscopy and Theatres to improve the oversight and discussion of clinical issues. Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board	To explore opportunities for a Clinical Director role for Planned Care (including Endoscopy and Theatres)	mar-22		Complete		Complete		Interim Assistant Medical Director Planned Care post in place from Sept 23. Permanent 6 session Assistant Medical Director Planned Care Role developed to be advertised subject to funding 24/25. New Senior Clinician Theatre Endoscopy post appointed to in Oct 23. New Senior Clinioical Leadership team are reviewing staffing and service SOPs to complete Q1 2024/5. Organisation Repatriation Programme established pending funding.	WG Funding	Risk Register	28.09.2023	Yes	14		mai-23	jan-22		
212206	Theatres Utilisation	Reasonable	Director of Operations	Assistant Director of Community Services Group	R2	Progress on delivering the Theatres and Endoscopy Recovery Plan should be appropriately controlled and monitored to ensure that the 2021/22 Renewal Priorities are achieved.	Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board.	mar-22		Complete		Complete		Planned Care Diagnostics Board Establsihed in 2022/23 to monitor recovery progress also reported via Integrated Performance Framework. WG Recovery Measures Achieved for 2021/22. Organisation Repatriation Programme establsihed pending funding.	WG Funding	Risk Register	01.06.2023	yes	14		mai-23	jan-22		
212206	Theatres Utilisation	Reasonable	Director of Operations	Assistant Director Community services	R3	The Service Level Agreements for the in-reach staff should be reviewed and updated as soon as possible.The assumptions and calculations within management information should be reviewed and updated as soon as possible. Agreed Management Action 3	To review service level agreement with in reach providers, this is challenging due to current seasonal pressures focus and all providers re-aligning/transforming services and implanting recovery plans. Management reports will be aligned with updated SLAs as part of 2022/23 service planning.	mar-22		Complete		Complete		All SLAs to be by the end of Sept as part of managing the overall financial position of the HB. Update - revised focus at CQPRM meetings will see SLA performance discussed more frequently including supplementary operational meetings. There remains a certain level of fragility in the inreach relationships due to at times, a higher level of need withiin the host provider. Feb 23 update - CQPRM meetings include enhanced oversight. the Commissioning Team's programme of work for 23/24 includes a formal review of this area and the application of a consistent approach to all inreach SLA's. On-going rolling review of SLAs/Enhanced Commissioning Support from Apr 23 to ensure all SLAs current.	Complexity of multiple in reach providers. Service capacity. DGH fragility.		31.03.2025	yes	23		feb-24	jan-22		
212206	Theatres Utilisation	Reasonable	Director of Operations	Assistant Director of Community services	R4	The actions put in place should continue to be monitored to ensure that they mitigate the risk of failing to achieve access targets including Referral to Treatment and National Endoscopy Programme Joint Advisory Group Training Site re-accreditation.	Plans in place monitored via Delivery & Performance Committee and Diagnostics, Ambulatory Care & Planned Care Board Programme, PTHB Integrated Performance Report.	Ongoing		Complete		Complete		Planned Care Board in place from 2022/23. Performance escalation and monitoring reporting to Board via PTHB Integrated Performance Framework.			01.04.2023	yes	#VALUE!	#VALUE!	feb-24	jan-22		
212206	Theatres Utilisation	Reasonable	Director of Operations	Planned Care Manager	R5	The Health Board should develop a protocol which describes the administrative processes which are in place regarding theatre utilisation.	Terms of Reference for Theatre Planning Meeting will be formalised and admin processes for list planning added to the SOP.	jan-22		Complete		Complete		Terms of Reference are now in place. Utilisation picked up as part of GIRFT review.Operational theatre report to be revamped in line with GIRFT expectations			jun-23	yes	25		feb-24	jan-22		
212208	Waste Management	Reasonable	Director of Strategy, Primary Care and Partnerships	Service Improvement Manager	R1	The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The THB should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements. The new document, once approved, should be published online. Superseded documents should be removed from the intranet.	Agreed. The core document is already in place and is currently out for consultation with Waste Group members. Agreed. The updated document will be signed off as a Policy at Executive Committee.	mai-22	des-22	Complete		Complete		Some further changes to the document are required. The document will then go through the process that will close with consideration by the Board. We have reviewed the document following completion of our contract award, but also reflected on progress in other HBs -and our document will be finalised and through necessary governance by December 2022 14/2/2024 - Waste management policy has now been updated and implemented.	Obtaining an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the revised document by the Board. Extention to deadline requested due to committee timetables.	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	nov-22	Completed A	21	14	feb-24	apr-22		
222303	Security Services	Reasonable	Director of Strategy, Primary Care and Partnerships	Assistant Director of Support Services	R2	Management should remind all Departmental Managers of the requirement for having Security Protective Measures plans in place for their areas of responsibility. Management should consider developing a template for the Security Protective Measures Plans for Security Leads to complete. This will allow for consistency in the information being recorded.	An internal communication will be made to all Departmental Managers advising them of the latest version of the Security Protective Managers Policy and its location on Sharepoint. b. This action will be discussed further during the next Security Oversight Group Meeting in December with the meeting invitation distribution List extended and updated to include a wider representation from all Departments across PTHB. A 30 minute slot has been reserved on the agenda for the next Site Coordinators Meeting and Health and Safety Groups in January 2023, to discuss the Security Protective Measures Policy and to deliver the toolbox talk on the preparation of Departmental Security Plans.To date, Departments have been encouraged to use the standard risk assessment template to develop Security plans as it provides a template to assess existing risks with a revised risk following risk mitigation and consideration. A dedicated template document will be developed to record Security plans and this will be presented to the December 2022 Security Oversight Group Meeting for consideration and approval, along with potential for approval at the Health and Safety Group if necessary.	feb-23		Complete		Complete		Due to change over of Assistant Director role further work is planned around the template for Security Plans to be disucssed at HSG and SOG. Security Oversight Group attendance extended to cover more service representatives. Communitcation around Site Security, new web pages, Policy and future survey will be shared via Powys Announcements in April 2023 The PTHB Risk Assessment form as a template document for Departmental Security plans. JM will amend a current document with some topic headers to aid evaluation and add to the Security Site on Sharepoint 14/2/2024A new Security Resource Page is being launched on the 26/2/2024 launched which reminds services of the need for seurity plans and also to use the risk assessment standard tool and risk maangement plan as the secuirty plan for the site. These actions have been agreed and shared with Directorates via the Security Oversight Group.					12	12	feb-24	nov-22		
222303	Security Services	Reasonable	Director of Strategy, Primary Care and Partnerships	Assistant Director of Support Services	R3	Management should consider reviewing all Security Plans at least annually at an appropriate forum such as the Security Oversight Group.	Security plans will be reviewed annually through the governance structure which will consist of the Security Oversight Group, The Health and Safety Group and the Site Coordination Forum. Security plans will be completed and filed centrally using Sharepoint, to ensure that Departments are referencing up to date policy documentation and forms.	des-23		Complete		Complete		Business cycle from April 2023 will include cycle of site based audits for review by the group to establish annual reviews. AN example of a Security Assessment is to be shared with Services in April to prompt awarness and work to improve the Web Site Resources will be made available. 14/2/2024 Managers have eben advised of this repornsibility and supported wit training presentations. Security Oversight Group will be auditing a set of sites in 2024 as part of routine arrangements and reporting back.					2	2	feb-24	nov-22		
222306	Decarbonisation	Not Rated	Director of Strategy, Primary Care and Partnerships	Director of Environment	R2	The governance arrangements surrounding the respective work groups assigned specific initiatives and corresponding actions should be aligned to those set out in the paper presented at the Innovative Environment Group, with enhanced accountability for delivering plans formally set out.	This action will be considered when a new version of the Decarbonisation Plan is developed. The current plan does have actions through to 2030 however there is a current expectation that a revised plan will be submitted as part of the IMTP planning cycle for 2024/25 onward. It is however necessary to not focus all actions on decarbonisation and climate impact on a single plan if we are to embed the issue in all departmental plans.	des-23		Complete		Complete		The Decarbonisation Strategic Delivery Plan has been reviewed and resultant actions have been allocated to a series of specific groups (Capital Control Group, Environment and Sustainability, Buildings and Biodiversity, Travel and Transport, Property and Accommodation, etc.) with standing meeting agenda items where the requirement is discussed and progress monitored and recorded. The actions have been mapped across to the groups with the appropriate remit to address the matters allocated and the process is working well in practice, with oversight by Environment and Sustainability Group with escalation/reporting to Innovative Environments Group. The Estates Head of Technical Services manages and coordinates the plan and associated updates.				Yes	2	2	feb-24	nov-22		
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	R2	The Health Board should implement a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions regulated by the HCPC and other professional bodies.The structure should also include a forum that oversees, advises and coordinates appropriate application of professional accountability and use of professional title for Health Board Therapy and Health Science professionals which are currently in place within the four departments sampled.	Implementation of a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions.	okt-23		Complete		Complete		Draft framework document complete, circulated for comments to Professional Leads October 2023. To be finalised and approved at next Professional Leads meeting December 2023. Professional Leads forum established and meets bimonthly. Complete, approved at Professional Leads meeting December 2023.					3	3	feb-24	mar-23		
222319	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R5	As a form of good practise, management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence. Through other audits undertaken, we have seen this as an area of good practise.	Review the structures in place within the service groups	mai-23		Complete		Complete		Audit is completed during rapid reviews as directed by the PTHB IMF. This is then 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 is reported at the beginning of every month to the executive Committee.	No barriers identified	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	Reviewed August 23		8	8	feb-24	mai-23		
222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R5	Management need to ensure that the invoice numbers and dates are accurately recorded in all systems, and correspond to the actual invoice. Management need to ensure that the rate of pay is correct before authorising the invoice for payment.	The standard operating procedure for invoicing will be reviewed to ensure that both the TSU and Finance are clear of their responsibilities in the process. This will include checks on invoice numbers, dates are accurately recorded and rates of pay are correct. A new self-billing process is being implemented for on-contract Agencies which will remove a number of the current manual checks required for invoice payments, improving accuracy.	jun-23		Complete		Complete		Standard Operating Procedure has been reviewed and includes the checks that need to take place for invoicing. The plan is to still implement Self Billing and we are at the testing stage, however the SOP and checks that we currently have in place satisfy the recommendation in terms of checking the invoice					8	8	feb-24			
222323	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	R1	Risk awareness and management of risks training should be implemented as soon as is practicable at all levels of the organisation in accordance with the stated requirements of the Risk Management Framework.	An implementation plan for Risk Management Training has been developed with the following key components due to be undertaken in 2023-24: • Delivery of Risk Appetite Training to the Board • Delivery of Powys specific Risk Management Training to the RAG at either the September or November 2023 meeting • Ad-hoc Powys specific training to services upon request, a timetable for this is currently under development via an Executive engagement exercise • Generic Risk Management Training available centrally funded to all staff via the University of South Wales/Intensive Learning Academy	mar-24		Complete		Complete		Nov 2023 update - Risk training inclduing risk appetitie delivered to Board Oct 2023. Risk training scheduled for the Risk & Assurance Group in February 2024. Generic Risk Management Training available centrally funded to all staff via the University of South Wales/Intensive Learning Academy. Feb 2024 - Risk and governance training (incl risk appetite) delivered to the Board in Nov 2023. Risk and governance training scheduled for Risk & Assurance Group 4 March. all other training consistently available via directorates and via USW academy.							feb-24			
222324	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	R2	The Corporate risk register should be submitted to the ARAC in accordance with the stated requirements of its ToR and Programme of Business. However, should management decide that the Corporate Risk Register is not to be submitted to the Audit & Risk Assurance Committee then the Terms of Reference of the committee should be amended.	The ToR will be amended so that the CRR does not require frequent review of the register itself, the Committee should be focussed on the risk management system itself and its implementation.	jul-23		Complete		Complete		The Terms of Reference will be updated in line with the annual review process for all committees and presented to the March 2024 Board meeting. The ToR review is on the agenda for the January ARAC meeting for the Committees own consideration. Feb 2024 - item on March ARAC agenda for March, TOR review drafted for committee consideration.							feb-24			
232409	Clinical Audit	Reasonable	Medical Director	Medical Director	R3	Management should consider updating future closure reports presented to the Patient Experience, Quality and Safety (PEQS) Committee to include outcomes and feedback on completed audits.	The Medical Directorate will ligase with the Chair of the Patient Experience Quality and safety Committee to agree the level of detail required in any future Closure report.	mar-24		Complete		Complete							#NUM!	1489	feb-24	nov-23		
232410	Clinical Audit	Reasonable	Medical Director	Medical Director	R4	The timing of audits within the 2023-2024 Clinical Audit Programme should be reviewed as it may be beneficial if some of the audits could be reprioritised to avoid so many requiring completion at the same time and risk them not all being completed which, as noted under Matter Arising 2, was the case in 2022-23.	The agreed management plan will be shared with colleagues from the operational services to outline the benefits of a Clinical Audit Program that is better distributed across the months.	des-23		Complete		Complete							2	1489	feb-24	nov-23		
232411	Clinical Audit	Reasonable	Medical Director	Medical Director	R5	Management should advise all staff undertaking clinical audits that all clinical audit files should be stored in a way that allows them to be easily accessed and referred to.	The agreed management plan will be shared with colleagues from the operational services to ensure that they recognise the importance of good document management.	des-23		Complete		Complete							2	1489	feb-24	nov-23		

232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education/Clinical Education Administrator	R2	Management should review the current 'version' of the Induction Tracker to determine what information currently recorded is surplus to requirements and consider what additional information should be included	A review of the induction tracker will be undertaken to clarify what needs to be recorded, what's currently missing and what is no longer required to be recorded.	jan-24		Complete		Complete		FEB 24 - Review of tracker fully completed. Version control is also added					1	1489	feb-24	jan-24
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education	R4	Management should ensure that portfolios are being completed within the required 12 weeks wherever possible. Linked to Recommendation 2 above, the Clinical Education team should ensure the Induction tracker provides details in a more comprehensive way to indicate reasons or identify a pattern as to why there may be a delay in completing or withdrawing from the Induction Programme.	An SOP will be developed to manage reminders and requests for completed portfolios. This link also link to 2.0 above.	jan-24		Complete		Complete		FEB 24 - Tracker updated to include reminders and requests. SOP included as part of R1					1	1489	feb-24	jan-24
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education	R5	They may also benefit from raising this as an issue at the All Wales HCSW Operational Meeting to establish whether there is a way to help shorten the process, or ascertain whether this is a consistent issue across Wales.	The Head of Clinical Education will seek advice at the next HCSW all Wales meeting.	nov-23		Complete		Complete		Completed					3	1489	feb-24	jan-24
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Assistant Director of OD	R6	Management should ensure a robust process for regular reporting or monitoring mechanisms for the HCSW Induction Programme is implemented within the Department that will also include providing updates at Board Level.	Updates on the HCSW induction programme will be included within the Director of Workforce and OD's (DWOD) update reports that are submitted to committee groups such as: Executive Committee, Local Partnership Forum, Workforce and Culture Committee.	jan-24		Complete		Complete		Information and data on HCSW induction included in DWOD report to Execs 21/2/24 and for onward assurance at Workforce and Culture Committee 5th March 24					1	1489	feb-24	jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R5	Management should ensure that an annual report for Health & Safety for 2023/24 is drawn up and submitted to the appropriate committees for consideration before final submission to the Health Board meeting scheduled for March 2024.	Management will establish an annual cycle for the delivery of the annual report	mar-24		Complete		Complete		Complete	None		mar-24		#NUM!	1489	feb-24	jan-24
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R6	With regards to regular updates on Health & Safety matters being reported to an appropriate committee of the Board, management need to clarify which committees should receive updates from the Health & Safety Group and update the group's ToR accordingly as well as the Health & Safety policyMar	Management will confirm as part of the corporate governance structure which committees will receive updates from Health and Safety Group which will be reflected in the TOR and also the Health and Safety Policy	mar-24		Complete		Complete		Complete. from April 2024 HSG will meet every 3 months and report to workforce and culture committee every quater and there will be an annual reprt every year.	None		mar-24		#NUM!	1489	feb-24	jan-24
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Governance Leads	R2	A training needs analysis be undertaken to ensure that staff understand the incident reporting process and are effectively assessing the level of harm caused. Senior management from service areas should engage and coordinate any identified training requirements with the Quality and Safety Team.	Governance leads for service groups to complete a training needs analysis to highlight staff members that have not completed Datix Incident Management training	mar-24		Complete		Complete		Staff members have been identified and allocated attendance at next available training session. Individualised team training has also been offered in addition to discuss bespoke issues.	NIL	Completed local review of sc	Completed	Yes	#NUM!	1489	feb-24	jan-24
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R5	Arrangements be put in place to ensure that Nationally Reportable Incidents are reported to the NHS Wales Executive in line with the required timescales set out in the National Policy on Patient Safety Incident Reporting & Management (March 23).	Monitoring of arrangements in place to ensure incidents are reported in a timely manner to the NHS executive. Monthly reporting to Executive Committee to ensure executive oversight	jan-24		Complete		Complete		Monthly reporting to executive Committee commenced in September 2023 to ensure oversight of incidents open b service	No barriers identified				1	1489	feb-24	jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	Director of Corporate Governance	R6	The Health Board should consider re-establishing submission of quarterly IG performance and Records Management Improvement Plan reports to the Executive Team and Delivery and Performance Committee	Accept: For 23/24 IG Performance report submission will be increased with a submission to the Delivery and Performance Committee in December 2023 and IG annual report submission in April 2024. 24/25 business cycle for IG and Records Management reporting will be agreed ahead of March 2024.	mar-24		Complete		Complete		5/2/24 - meeting has taken place to review the 2024/2025 business cycle and re-establishment of quarterly IG performance and Records Management Improvement updates has been reinstated.					#NUM!	1489	feb-24	jan-24

Mills Belinda
11/03/2024 17:12:59

APPENDIX 3 - Internal Audit Recommendations NOT YET DUE

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	Progress of work underway	Barriers to implementation	How is the risk identified being	When will implementation be	If action is complete, can evidence	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	for Closure
202115	Winter pressures and flow management	Reasonable	Director of Operations	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		Not yet due		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 disharge guidelines have been circulated for comment. The discahrge 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	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		01/02/2024 - Relucant to leave 28/2/24 - Discharge guidance		22		feb-24		NO
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.	des-23		Not yet due		No progress							#NUM!	#NUM!	mai-23	jan-23	
222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure and Cyber Security	R1	Progress reporting should contain enough granular detail to enable progress achieved to be accurately tracked and accurate quantification of what remains to be achieved; especially as the ultimate goals will always be changing. E.G. out of support software will always decrease/increase as time passes The software tools available should be configured to provide accurate information on activities related to key objectives. onthly KPI should be produced for senior management. They should be detailed enough to identify the ongoing cyber security position and specifically related to the key objectives of the cyber improvement plan.	Agreed and Action This has been an area of ongoing focus, action and improvement. Significant progress has been made in addressing legacy operating systems, patch compliance and coverage against known assets but it is acknowledged that the reporting of this against internal KPI's and industry to support best practice requires further improvements to provide assurance. Work has already started on developing the required reports and rationalising the tooling (Intune, SCCM, Autopatch) used to ultimately deliver more useful and relevant reports and implement the appropriate KPI's to manage this longer term. As evidenced, the data exists and this will be provided specifically in monthly performance reports for senior management, aligned to the Cyber Improvement Plan and related KPI's.	jun-23		Not yet due		Partially complete		The development of monthly KPI's has begun with an initial focus on Active Directory. Some progress has been made with Backup Reporting but isn't yet something that can be developed into a KPI. The implementation of New Backup Hardware procured at the end of 2022/2023 will allow additional focus on this area of cyber resilience and subsequent assurance reporting.					7	7	feb-24	mar-23	
222321	Performance Management and Reporting	Substantial	Director of Performance and Commissioning	Chris Moss	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).	des-23		Not yet due		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.							feb-24		
222328	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	R6	Corporate Governance Department should ensure that ongoing progress is maintained so as to enable completion and sign-off of the Board Assurance Framework by the Board in accordance with the prescribed Risk and Assurance Forward Plan 2023/24 timescale.	The BAF is in development, an initial working copy will be in place Autumn 2023 with a final copy approved for 1 March 2024.	mar-24		Not yet due		Partially complete		Nov 2023 update - The BAF is in development and on track for the target deadline of 31 March 2024. Feb 2023 - on track for 31 March, update scheduled into ARAC for March 2024 meeting.							feb-24		
232402	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of 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.	des-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.					2	1489	feb-24		
232405	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of 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.	des-23		Not yet due		Partially complete		This is linked to action 232402 and 232404					2	1489	feb-24		
232408	Clinical Audit	Reasonable	Medical Director	Medical Director	R2	The Health Board should ensure that sufficient resources are available for clinical audits so that the annual Clinical Audit Programme is fully delivered.	The agreed management plan will be shared with colleagues from the operational services to ensure that prioritisation of audits is understood.	des-23		Not yet due		Partially complete		Cascaded to clinical and opertaional execs. Evidencing may be difficult but would be evidenced by delivery of the clinical audit plan. Teams asked to reflect back if they do not think they have capacity for clinical audit. Marked as partially complete. Will mark as copmplete at next review if teams have not fed back concerns re capacity.					2	1489	feb-24	nov-23	
232413	Clinical Education - HCSW Induction Programme	Reasonable	Director of Workforce and OD	Head of Clinical Education	R3	Linked to Matter Arising 1, management need to ensure that the process developed includes information to managers to help to aid with the identification of all staff eligible to register/enrol on the HCSW Induction Programme to avoid unnecessary training sessions being scheduled and then ultimately cancelled. Medium Agreed Management Action Target Date	In support of R1 a process flow/criteria will be provided to recruitment managers that identifies those eligible to undertake the HCSW induction programme and how to sign/ book them onto the induction course.	mar-24		Not yet due		Partially complete		FEB 24 - In conjunction with data / information on process flows from other Health Boards a new internal process flow is being created. On track for completion End March					#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R1	Management should ensure that where policies have been reviewed, the new updated versions are published on the Intranet as soon as possible and the old versions taken off. For those policies that are overdue for review management need to ensure that they are reviewed and updated as soon as practicable.	Management will review the version control of relevant H&S policies and ensure they are updated in a timely manner	mar-24		Not yet due		Partially complete		All H&S linked policies are being reviewed so they correspond correctly to each other and the revised meeting schedule. This requires a detail reading of the policy, maaking amendments, then they will go back to HSG in March for ratification and then published before April	None		apr-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		apr-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		jun-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None		mar-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R7	Management should consider introducing a standing agenda item for H&S training compliance review at the Health & Safety Group meeting. This will enable the group to review areas of low compliance and agree appropriate actions.	Management will change the standing agenda item to include a dedicated item on H&S training compliance to ensure there is a focus on low compliance and to agree appropriate actions.	mar-24		Not yet due		Partially complete		Training compliance is now a standing agenda item and also is reported by services as part of the highlight reports	None		mar-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	Assistant Director of Support Services - Health and Safety	R8	Management should ensure that for the information reported on statutory and mandatory training compliance that a standard format is agreed so that all departments are reporting the same information and that the reporting period is also the same	Management will introduce a standard format for the reporting of mandatory and statutory training	mar-24		Not yet due		Partially complete		Work is gongoing to identify which trainig is to be reported on a standard temlate for the group and will be finalised at the March HSG	None		mar-24		#NUM!	1489	feb-24	jan-24	
232414	Helath and Safety Arrangements	Reasonable	Director of Therapies and Health Science	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	None	0	mar-24		#NUM!	1489	feb-24	jan-24	
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	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							0	1489	feb-24	jan-24	
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	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.	Process	Completed local review of scheme of delegation and sign off procedures i			#NUM!	1489	feb-24	jan-24	
232415	Incident Management	Reasonable	Director of Nursing & Midwifery	Director of Nursing & Midwifery	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	mai-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					#NUM!	1489	feb-24	jan-24	
232416	Information Governance	Limited	Director of Finance, Information and IT	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.	mai-24		Not yet due		Partially 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.					#NUM!	1489	feb-24	jan-24	
232416	Information Governance	Limited	Director of Finance, Information and IT	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 authority 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		Not yet due		Partially 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					0	1489	feb-24	jan-24	

232416	Information Governance	Limited	Director of Finance, Information and IT	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 bi -annually, to discuss progress the Information Asset Register agenda and promotion of good Information Governance practices across the organisation.	mar-24		Not yet due		Partially 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					#NUM!	1464	feb-24	jan-24
232416	Information Governance	Limited	Director of Finance, Information and IT	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		Not yet due		Partially complete		see entry above					#NUM!	1464	feb-24	jan-24

APPENDIX 4 - External Audit Recommendations OUTSTANDING

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any	How is the risk identified being mitigated pending	When will implementation be					
222302	The National Fraud		Director of Finance, Information and		R1	All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is		Ongoing		Overdue		Partially complete							#VALUE!	#VALUE!	feb-24	nov-22
222302	The National Fraud		Director of Finance, Information and		R2	Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are		mar-23		Overdue		Partially complete							10	10	feb-24	nov-22
222302	The National Fraud		Director of Finance, Information and		R3	Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take		Ongoing		Overdue		Partially complete							#VALUE!	#VALUE!	feb-24	nov-22
222303	Review of the Strategic		Director of Strategy, Primary Care		R1	Independent members were engaged in the development of the Annual Plan for 2021-22 and the renewal priorities. However, since this time		Ongoing		Overdue		Partially complete		As part of IMTP planning for 23/24 and the wider focus on system working, PTHB has embarked on a piece work look at long term sustainability of services. This piece of work titled "Accelerated Sustainability Model" will			By end of Mar 23		#VALUE!	#VALUE!	feb-24	jan-23

APPENDIX 5 - External Audit Recommendations COMPLETED

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any	How is the risk identified being mitigated pending	When will implementation be					
181951	Structured Assessment 2018		Director of Corporate Governance/Bo		R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be	okt-19	mar-21	Complete	2	Closed		Remains under review - with the approach to stakeholder engagement being formalised. Feb 2023 update - status remains as reported above, the action will form	Delayed in light of COVID-19 and changes in the corporate team	Clinical and Stakeholder engagement is	30-sep-23		51	34	feb-24	
202152	Structured Assessment 2020		Director of Corporate Governance/Bo		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither	•Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual	mar-22		Complete	2	Closed		See R2 above Feb 2023 update - as above in R2, REVISED DATE REQUESTED of 30/9/23. April 2023 update - as above in R2.	See R2 above	See R2 above	See R2 above		22	1489	feb-24	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Audit, Risk and Assurance Committee	**Date of Meeting: 11 March 2024**
Subject:	**WELSH HEALTH CIRCULARS AND MINISTERIAL DIRECTIONS**
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Officer
Other Committees and meetings considered at:	N/A

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 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.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✓

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

EXECUTIVE SUMMARY:

WHCs 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 22 February 2024 is as follows:

- For those WHCs received in 2018 there is 1 Complete (100%)
- For those WHCs received in 2019 there is 1 Complete (100%)
- For those WHCs received in 2020 there is 1 Complete (100%)
- For those WHCs received in 2021 there is 2 Complete (100%)
- For those WHCs received in 2022 there are 5 Complete, 5 Partially Complete and 2 Not Yet Due (42% complete)
- For those WHCs received in 2023 there are 15 Complete, 3 Partially Complete and 3 with No Progress and 2 Not Yet Due (65% complete)
- For those WHCs received in 2024 is 1 Complete (100% complete)

- For those Ministerial Directions received in 2023 there are 6 Complete and 1 Not Yet Due
- For those Ministerial Directions received in 2024 there are 2 Partially 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 actioned since the last reporting period.

Appendix 1 (outstanding WHCs) include a column with additional comments explaining the reasons for delay in completion, important content is included here for Committee understanding against specific WHCs.

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 following table provides an overview of the progress made against the implementation of WHCs received in 2018, 2019, 2020, 2021, 2022, 2023 as of 22 February 2024.

	2018	2019	2020	2021	2022	2023	2024
	Position at 11/03/24	Position at 11/03/24	Position at 11/03/24	Position at 11/03/24	Position at 11/03/24	Position at 11/03/24	Position at 11/03/24
No Progress	0	0	0	0	0	3	0
Not yet due	0	0	0	0	2	2	0
Partially Complete	0	0	0	0	5	3	0
Complete	1	1	1	2	5	15	1
TOTAL NUMBER ISSUED	**1**	**1**	**1**	**2**	**12**	**23**	**1**

The tables below identify those WHC's which are overdue at the time of reporting.

Overdue WHCs 2022 - 2023			
WHCs No	**Name of WHC**	**Expected Date of Completion**	**Lead Executive**
2022/018	Guidelines for managing patients on the suspected cancer pathway	Immediate	Medical Director
2022/006	Direct Paramedic referral to same day emergency care	Immediate	Director of Operations/Director of Planning, Performance and Commissioning
2022/032	Further extending the use of Blueteq in secondary care	01/04/2023	Medical Director

2023/021	Consent to Examination or Treatment - update	Immediate	Medical Director
2023/030	New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034	Immediate	Director of Finance and IT/Medical Director
2023/036	Speaking up Safely Framework - NHS Wales	30/10/2023	Chief Executive Officer
2023/040	The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)	01/11/2023	Director of Finance, Information and IT
2023/046	All Wales Control Framework for Flexible Workforce Capacity	13/12/2023	Chief Executive Officer/Director of Finance, Information and IT, Director of Workforce and OD, Medical Director

The table below identifies the WHC's that are awaiting update from colleagues at the time of reporting:

WHCs awaiting January 2023 update			
WHCs No	**Name of WHC**	**Expected Date of Completion**	**Lead Executive**
2022/018	Guidelines for managing patients on the suspected cancer pathway	Immediate	Medical Director
2022/006	Direct Paramedic referral to same day emergency care	Immediate	Director of Operations/Director of Planning, Performance and Commissioning
2023/046	All Wales Control Framework for Flexible Workforce Capacity	13/12/2023	Chief Executive Officer/Director of Finance, Information and IT, Director of Workforce and OD, Medical Director

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 October 2024 to both Executive Committee and Audit, Risk and Assurance Committee.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2022-005	Data Requirements for Value Based Health Care	24/03/2022	The basis of the WHC and subsequent processing of information is made in consideration of: Section 1 of the National Health Service (Wales) Act 2006 which places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales, and in the prevention, diagnosis and treatment of illness. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty. Pursuant to Section 3 of the National Health Service (Wales) Act 2006 the Welsh Ministers have a statutory duty to, inter alia, provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements, healthcare services and such other services or facilities as they require for the diagnosis and treatment of illness. Pursuant to Section 12 of the National Health Service (Wales) Act 2006, the Welsh Ministers may direct a Local Health Board to exercise in relation to its area functions relating to the health service. Pursuant to the Local Health Board (Directed Functions) (Wales) Regulations 2009, the duty under Section 3 of the 2006 Act has been delegated to the Local Health Boards and are thus responsible for the provision of health services in Wales. Pursuant to Section 18 of the National Health Service (Wales) Act 2006, the Welsh Ministers may by order establish NHS trusts to provide goods and services for the purposes of the health service. Pursuant to Section 19 of the National Health Service (Wales) Act 2006, the Welsh Ministers may give directions to an NHS trust about its exercise of any functions. The supply of data to facilitate the work of the Welsh Value in Health Centre and in particular to continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms falls within the statutory functions of the Local Health Boards and the Trusts. Pursuant to Section 22 of the National Health Service (Wales) Act 2006, the Welsh Ministers may by order establish special bodies, known as a Special Health Authorities, for the purpose of exercising any functions which may be conferred on them. Pursuant to Section 24 of the National Health Service (Wales) Act 2006 the Welsh Ministers may direct a Special Health Authority to exercise any of the functions of the Welsh Ministers relating to the health service which are specified in the directions. Section 23 of the National Health Service (Wales) 5 Act 2006 provides that the Welsh Ministers may give directions to a Special Health Authority about its exercise of any functions. The Digital Health and Care Wales (Establishment and Membership) Order 2020 ("the Order") came into force on 30 December 2020 and established Digital Health and Care Wales ("DHCW") as a Special health Authority and made provision about its functions and membership. Article 3 sets out the nature of DHCW's functions which are to be specified more particularly in directions given by the Welsh Ministers under Section 24 of the National Health Service (Wales) Act 2006. DHCW's functions relate to, inter alia, the collection, analysis, use and dissemination of health service data and any other matter so as to secure the provision or promotion of services under the National Health Service (Wales) Act 2006. For the purposes of the data flows already established within existing agreements, the following conditions from the GDPR are most likely to be relied upon in these circumstances: Article 6(1) (c) and (e): (c) processing is necessary for compliance with a legal obligation to which the controller is subject; (e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. Article 9(2) (h) and (i): (h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3; (i) processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy. All parties have a responsibility for the accuracy, integrity and confidentiality of the information shared in these circumstances.	Director of Finance and IT, Medical Director and Director of Primary, Community Care and Mental Health	31/03/2025	Partially Complete	Jan 2024 - All Wales Outcomes (PROMs) Framework has five suppliers on it. BCUHB, CTMUHB, HDUHB and SBUHB have carried out a mini competition to select a preferred supplier from the five on the framework which they would then all use. PTHB, along with C&VUHB and Velindre NHS Trust had observer status to help inform what they do in relation to PROMs. PTHB colleagues including Transformation Programme Manager, Head of Data Infrastructure and Advanced Information Analyst continue to enagage in the relevant National PROMs sub groups. August 2023 - PTHB is continuing to work to implementing a PROMS solution that is aligned to the National Framework being enabled by DHCW. While a specific solution has not yet been selected, it will be aligned to the interoperability & integration standards for NHS Wales to ensure that Data is recorded in a consistent manner to create a true National picture of PROMS in NHS Wales. This data can be fed in DHCW and the National Data Resource programme which in turn will mean that National Dashboards can be created. February 2023 Powys continues to participate in the small number of National Clinical Audits and Outcome reviews where it offers a relevant service. These are; National Diabetes Foot Care Audit All Wales Audiology Audit Sentinel Stroke National Audit Programme National Audit of Care at the End of Life National Confidential Inquiry into Suicide and Safety in Mental Health Maternal, Newborn and Infant clinical Outcome Review (MBRRACE) CIVICA continues to be rolled out for PREMs collection in Powys. On 09/11/22 PTHB Executive Committee approved the use of EQ-5D-5L as the 'generic' organisational PROM, with condition specific PROMs 'layered' on top. A PROMs Implementation Task & Finish Group has been established to consider the options for the deployment of an organisational approach to PROMs for PTHB. This work will also align to the All Wales Outcome Framework being developed by the Welsh Value in Health Centre. The national group is also currently undertaking the 'quality' assessment of the tenders, then will move to financial analysis. Oct 2022 Action on going to develop PROM and PREM data within the Health Board and to ensure aligned to WHC requirements, also linking in with Value in Health to align to national approach re PROM and PREM. Agreement from VBHC Programme Board on 24.05.2022 to link and track through VBHC Programme Plan.
2022-012	Donation and Transplantation Plan for Wales 2022-2026	16/06/2022	Health Boards and NHS Trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their Integrated Medium Term Plans (IMTPs).	Medical Director	31/12/2026	Partially Complete	January 2024 Integrated Plan for submission end of March 2024 to ensure that this reflects the priorities from the Donation and Transplantation Plan for Wales and PTHB continued participation through WHSSC Joint Committee and Management Group with input to the priorities referenced within the WHSSC Integrated Commissioning Plan 24/25. Also PTHB through CQPRMs will continue to seek assurance from commissioned service providers on implementation of the All Wales Plan. September 2023 Specialised Services commissioned through joint statutory committee of 7 health boards including PTHB. PTHB actively participates in the WHSSC Joint Committee and WHSSC Management Group. WHSSC Integrated Commissioning Plan 2023/24 references: o Welsh Renal Network is the vehicle through which specialised renal services are planned and commissioned on all Wales basis and manages utilisation of ring-fenced funds on behalf of WHSSC to commission renal transplantation services with priority identified in plans for 2023/24: Value in Healthcare programme to support delivery of Organ Donation and Transplantation Plan for Wales with desired outcome of pre-habilitation programme adopted by Q4. PTHB as a provider of services, and as a commissioner of services for Powys residents from a large number of NHS Wales Health Boards and NHS England Trusts will: o Work with and seek assurance from commissioned service providers via regular Contract Quality and Performance Review Meetings (CQPRMs) on the implementation of the All Wales Plan. o Optimise communication efforts to raise awareness on decreased organ, tissue and eye donation and on living donation and transplantation. o Continue to work with WHSSC, Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the Donation and Transplantation Plan for Wales. o Ensure that the PTHB Integrated Plan continues to reflect the importance for the health board on the scope and nature of specialised services including movements between secondary and tertiary services, major new developments and that the Health Board will work with WHSSC to improve value through a focus on improved outcomes, experience and cost.
2022 018	Guidelines for managing patients on the suspected cancer pathway	30/06/2022	The achievement of the cancer target is the responsibility of NHS Wales as set out in the quality statement for cancer. The underlying principle of the suspected cancer pathway is that patients should receive excellent care without delay. This document sets out the rules to ensure that each patient's pathway waiting time is consistent and unnecessary delay does not occur as patients pass between clinical teams and organisations.	Medical Director	Immediate	Partially Complete	August 2023 Version 4 of the guidance has been superseded by version 5-see below.February 2023 PTHB provides limited diagnostic services for cancer and minimal treatments. The majority of Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. Referral to treatment times are the responsibility of the Director of Planning and Performance for Commissioned Services and the Director of Primary, Community Care and Mental Health for directly provided services. Performance is monitored through the Integrated Performance Framework for the health board and regularly reported to the Board and relevant committees. The Cancer Renewal Programme has established a Harm Review Panel to review harm reviews undertaken by other health boards and NHS trusts treating Powys patients. October 2022 Update PTHB provides limited diagnostic services for cancer and does not provide any cancer treatments. Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. The Cancer Renewal Programme has established a Harm Review Panel to review on breach reports and pathway reviews completed by Commissioned Providers to identify factors causing delays to inform future planning of services and commissioning to follow up. A Cancer Tracker role has been created as part of this process. PTHB is also developing a Power BI Tool to enable live tracking of Powys residents on urgent suspected cancer pathways to identify patients who are at risk of breaching and who are breaching target waiting times to enable intervention. This process is in development.
2022 006	Direct Paramedic referral to same day emergency care	21/04/2022	In order to reflect local service models, each health board will need to agree with WAST the mechanisms for enabling the 'clinician to clinician' discussion, which forms the basis of the acceptance of patients into SDEC services.	Director of Primary, Community Care and Mental Health	Immediate	Partially Complete	17/02/2023 Emergency/acute care not commissioned within Powys. However, a range of actions being taken as defined in the Integrated Care ACtion Plan (ICAP), fully integrated with 6 Goals delivery and reviewed in montly monitoring arrangements. tOngoing work with commissioned partners to ensure quality, safe and timely care in Emergency Departments – annual cycle, alongside daily engagement with operational flow across National urgent care system.
2022/032	Further extending the use of Blueteq in secondary care	21/03/2023	Unless directed otherwise, Health Boards and NHS Trusts are required to act on the requirements set out in National Health Service (Wales) Act 2006 - Local health boards and NHS trusts reporting on the introduction of new medicines into the national health service in Wales directions 2023. The roll out of the system will be supported by the All-Wales Therapeutics and Toxicology Centre (AWTTC).	Medical Director	01/04/2023	Partially Complete	January 2024 - There are a number of outstanding questions relating to the DPIA, these are being addressed. Cyber issues have now been identified - these are being worked through. Jacqui Seaton, Chief Pharmacist, has flagged the challenges to Andrew Evans, Chief Pharmaceitical Officer (WG) and explained until all IG and cyber issues have been addressed, health boards across Wales cannot progress with Blueteq implementation August 2023 National Blueteq Steering Group established and meeting regularly (monthly), chaired by PTHB's Chief Pharmacist. Priorisation of areas for implementation agreed and published on the AWTTC website. DPIA in development (for adoption by all health boards). Once DPIA in place, impementation will begin.
2023 021	Consent to Examination or Treatment - update	08/08/2023	This Welsh Health Circular replaces WHC/2017/036. It sets consent in the context of the framework of the Duty of Quality that is now in place in Wales. It also brings together in one place links to materials, guidance, and training information developed and promoted by the NHS Wales Welsh Risk Pool, to support NHS organisations in Wales to approach the taking of	Medical Director	Immediate	Partially Complete	January 2024 The Workforce Department within the Health Board is currently identifying all the staff who will be required in future to undertake the All-Wales e-learning materials on Consent. Once this work is complete there will be regular reports to the Executive Team on staff compliance in undertaking the consent training. The Powys Community Dental Service is keen to move to an all-electronic notes system and is investigating ways that the taking of consent can be recorded electronically. January 2024 Training needs analysis undertaken by OD team to identify eligible staff and advice received from WRP incorporated into this assessment.
2023 030	New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for	11/08/2023	NatSSIPs2 have been developed in collaboration across the four UK nationsand replace the 2015 NatSSIPs introduced in Patient Safety Notice PSN034. The NHS Wales Executive will not be issuing a new Patient Safety Notice since the actions required in PSN034 are equally applicable to NatSSIPs2.	Director of Finance and IT/Medical Director	Immediate	Partially Complete	January 2024 NatSSIPs are in place in OPD – completed NatSSIPs in Theatres are currently being reviewed by the clinical leadership team this will complete in early Q1 2024/5
2023 036	Speaking up Safely Framework - NHS Wales	01/09/2023	Dear Colleague, I am writing to you following my letter on 25 August 2023 to all NHS Wales Chief Executives about Quality and Safety systems in light of the Letby verdict. In the email I shared an important pillar of these systems - the Framework for Speaking up Safely in NHS Wales. The Framework has been developed, scrutinised and approved in social partnership to provide an all-Wales consistency of cultural expectation, approach and escalation process whilst also strengthening local initiatives. It is essential to enable NHS Wales staff to speak up about issues with confidence knowing their concerns will be taken seriously, heard fairly and that that they will not face personal repercussions for raising concerns.	Chief Executive Officer	30/10/2023	No Progress	
2023/040	The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)	09/11/2023	We would like to invite Health Boards to nominate a senior NIPEC lead within each Health Board, to form a national community of practice, pooling expertise with the aim of sharing good practice, and providing leadership on training, standards and implementation. Could Health Boards ensure they have sent details of their NIPEC lead nomination to hss-dph-populationhealthcare@gov.wales, marked for the attention of Children's Health Branch by 18 December 2023.	Director of Finance,Information and IT	01/11/2023	Partially Complete	10/11/23 shared with GP practices. Currently waiting for further guidance on go live date of the NIPEC new examination process. To support the changes, training being offered to practices in Spring 2024
2023/039	Independent Authorisation of Blood Component Transfusion (IABT)	01/11/2023	The All-Wales Policy for Independent Authorisation of Blood Transfusion (IABT) describes the process for selection, education, approval, and support of Health Care Professionals (HCPs) undertaking this role within Wales. For standardisation and safety reasons the only recognised route to practice is through acquisition of an agreed, accredited programme of education and assessment. HCPs undertaking the IABT role will have completed a specific Higher Education Institution (HEI) accredited programme of education and assessment, commissioned by Health Education and Improvement Wales (HEIW).	Medical Director	01/10/2026	No Progress	January 2024 needs MDT discussion woth Clinical Execs CR/CM/KW
2023/046	All-Wales Control Framework for Flexible Workforce Capacity	13/12/2023	This Circular focuses on the actions required to deliver a clear control framework for deployment of flexible workforce capacity. This control framework will be implemented within NHS organisations and coordinated on an all-Wales basis to drive best practice, provide transparency and fairness for our workforce, avoid inter organisation competition which unnecessarily inflates cost pressures across Wales and avoid unintended consequences for individual organisations. Whilst our headline focus is on reducing avoidable agency expenditure, the control framework will be applied to both agency and variable pay expenditure to aid transparency as costs move from the agency to variable pay categories. This will ensure that we realise the potential efficiencies rather than simply transfer costs.	Chief Executive Officer/Director of Finance,Information and IT,Director of Workforce and OD,Medical Director	05/01/2024	No Progress	
tenal Directions							

WG24-01	Wales Eye Care Services (Administrative List) (Wales) Directions 2024	05/01/2024	Each Local Health Board must prepare, for its area, an administrative list. (2) Subject to paragraph (3), the administrative list must consist of a list of the qualified practitioners who provide or assist in the provision of ophthalmic services and must contain the following information— (a) the qualified practitioner's full name; (b) the qualified practitioner's professional registration number; (c) the date of the qualified practitioner's first registration in the register; (d) the date that the qualified practitioner's name was first included in the administrative list; (e) the ophthalmic services that the qualified practitioner provides or assists with. (3) A Local Health Board is not required to include in an administrative list information about qualified (1) 2016 No. 11 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. (2) 2016 No. 10 as amended by WG20-44, WG21-11 (now expired), WG23-47 and WG24-02. 4 practitioners who are already included in a combined list prepared and published by that Local Health Board under regulations 10(1) and 11(1) of the 2023 Regulations. (4) Each Local Health Board must publish its administrative list and make a copy available for inspection at— (a) its offices, and (b) any other place in its area it considers appropriate. (5) Each Local Health Board must— (a) send a copy of its administrative list to the relevant Local Medical Committee and the relevant Local Optical Committee, and (b) at intervals of not more than 3 months, notify each of them of any alteration made in that list	Director of Finance,Information and IT	N/A	Partially Complete	February 2024 - PTHB is working with NWSSP who will produce the administrative list. This is progressing nationally and will be established for all health boards simultaneously.
WG24-02	The National Health Service (Wales Eye Care Services) (Wales) Directions 2024	05/01/2024	) The Eye Health Examination Service Committee (Wales) Directions 2016(2) are amended as follows. (2) In paragraph 1.1 of Schedule 1 (interpretation), at the appropriate places insert—""2023 Regulations" means the National Health Service (Ophthalmic Services) (Wales) Regulations 2023(3);"the Act" means the National Health Service (Wales) Act 2006;"; ""the administrative list" means the administrative list prepared and published by a Local Health Board in accordance with the Wales Eye Care Services (Administrative List) (Wales) Directions 2024(1);";	Director of Finance,Information and IT	N/A	Partially Complete	February 2024 - enhanced optometry services (WGOS3 and WGOS5 IPOS Urgent) have been established, arranging and accredited practitioner lists are held by NWSSP. WGOS4 is yet to be established nationally and will require the same process once launched.

WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments
2018-022	Sharing Patient information between healthcare professionals – a joint statement from the Royal College of Ophthalmologists and College of Optometrists	03/09/2018	To note that on 20 March 2015 the Royal College of Ophthalmologists and the College of Optometrists issued a joint statement encouraging ophthalmologists to share clinical information with the referring optometrist. To ensure hospital policies and procedures encourage this communication so that it becomes standard practice for planned and unplanned ophthalmology care in Wales.	Medical Director		Complete	January 2024 awaits Note PTHB action complete.Awaiting EPR.Timeframe is uncertain. August 2023. PTHB has been ready to implement the new EPR system since May 2022 but national systems issues continue. The lead for the national system implementation has transferred to DHCW who are currently reviewing all aspects with a revised national "go live" plan to be advised in Autumn 2023. February 2023 For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout Due to national system delays implementation date will not take place until Q1 2023/24. PTHB readiness was completed in May 2022 March 2022 For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout 22/23. Clarification of the current situation was sought from localities in September 2018. The north Powys locality confirms the destination of clinic letters is instructed by the consultant. Sending information back to the referrer (as well as the patient's GP) is inconsistent. The locality has agreed to draw the consultants' attention to the requirements of the new WHC. A response from the mid/south Powys locality is still being pursued. Update - The joint statement clarified best practice as writing to the referring optometrist as well as the GP. We can ensure that that is being done in Powys hospitals, but providers out of the county will have their own policies, hence I expect that the picture across Powys is variable. With the new EPR optometrists will be able to look at eye care records for their own patients, including clinic letters, so this will become moot. Of course this will not apply to our English providers.
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery Meetings.	Medical Director		Complete	ugust 2023 This WHC expired 30th March 2020 and should be closed. The latest AMR & HCAI Improvement goals are detailed in WHC 2023/031 which was published last month. February 2023 ALSO REPORTED UNDER DON Antimicrobial stewardship group established, meets quarterly and feeds into the IPC Group. Antimicrobial stewardship improvement plan in place. Primary care antimicrobial prescribing monitored monthly against a number of KPIs. Practices provided with KPI performance reports on a monthly basis. Antimicrobial stewardship discussed at all practice meetings and relevant targets included in the prescribing incentive scheme and relevant SLAs. Start Smart Then Focus (SSTF) undertaken by the Community Services Medicines Management Team. MicroGuide implemented to improve access to antimicrobial prescribing guidelines. October 2022 Update HCAI 2021/22 Full Year reduction expectations have all been met. C. difficile: Rate of 25 per 100,000 - Achieved S. aureus bacteraemia: Rate of 20 per 1000,000 population - Achieved E. coli bacteraemia: Rate of 67 per 1000,000 population - Achieved Klebsiella sp. Bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved P. aeruginosa bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved 8 years since last MRSA bacteraemia. March 2022 See also 2021/028 AMR & HCAI Improvement Goals For 2021-22 for more detailed update 5 year National Action Plan 2019 – 2024 underpinning the UK AMR Strategy 20: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Medical Director	Immediate	Complete	August 2023 - PTHB is continuing to work to implementing a PROMS solution that is aligned to the National Framework being enabled by DHCW. While a specific solution has not yet been selected, it will be aligned to the interoperability & integration standards for NHS Wales to ensure that Data is recorded in a consistent manner to create a true National picture of PROMS in NHS Wales. This data can be fed in DHCW and the National Data Resource programme which in turn will mean that National Dashboards can be created. February 2023 Survey of PTHB services to understand PROMs and PREMs already in use completed. Links made with Welsh Value in Health Centre (WViHC) to national work and contact made with English Integrated Care Systems to discuss PROMs and PREMs for Powys patients treated in England. Discussion with WViHC and DHCW about PROMs for Powys patients treated in other Welsh health boards and in English NHS Trusts suggests dataflows should allow this (may require DHCW approaching NHS Digital). February 2023 PTHB has continued to raise the importance of nationally developed dashboards including commissioner views and including English data for Welsh patients treated over the border to ensure that health boards can understand outcomes, cost and experience for all of their resident populations. Some of the recently launched, nationally developed dashboards, continue to be provider-focussed and/or do not include English data. PTHB colleagues are working with DHCW to address these issues. October 2022 Update. Survey of PTHB services to understand PROMs and PREMs already in use completed. Links made with Welsh Value in Health Centre (WViHC) to national work and contact made with English Integrated Care Systems to discuss PROMs and PREMs for Powys patients treated in England. Discussion with WViHC and DHCW about PROMs for Powys patients treated in other Welsh health boards and in English NHS Trusts suggests dataflows should allow this (may require DHCW approaching NHS Digital). A paper outlining an organisational approach to generic PROMs will be considered by PTHB Transformation & Value Group Executive Committee on 09/11/22. Work is underway in Powys in relation to: •Diabetes •Frailty •Eye Care (Cataracts) •Cancer •MSK (Orthopaedics) PTHB has continued to raise the importance of nationally developed dashboards including commissioner views and including English data for Welsh patients treated over the border to ensure that health boards can understand outcomes, cost and experience for all of their resident populations.

2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to provide updates at three monthly intervals from April 2021. Health Boards will be aware that there are two cohorts of children that will need “mopping up” due to the Covid-19 pandemic, communication of how this will be managed will follow with the “Standard Operating Procedure” and related documentation.	Director of Primary, Community Care and Mental Health	30/07/2022	Complete	Feb 24 Hearing Screening is undertaken by the SN service who are trained by audiology services. The screening is delivered as per the Wales pathway. Audiology service update- the pathway is led by audiology and is meeting the requirements of the circular. September 2023- School Nursing service continues to manage and deliver the hearing screening in combination with the Child Measurement Programme where they measure height and weight. Vision screening is also carried out at this time. 3 contacts are offered for each child. An opt-out letter is sent to parents. 16.02.2023 Screening remains with the SN Services and no new update has been received from Audiology Services. 17/10/2022 progress continues with communications between audiology and school nurses, screening remains with SNs. Led by the PTHB Head of Audiology, in conjunction with School Nursing service with Powys, this has already progressed some key elements. Expectation of quarterly updates prior to full implementation no later than April 2022.17.06.2022 - Discussions ongoing, Head of Audiology leading, SBAR completed by Head of Audiology with Standard Operating Procedure also in process of being completed by service. Audiology requesting screening remains with School H7 Nursing with their oversight. Discussions planned between Audiology and School Nursing in coming weeks with a view to completing implementation September 2022. School Nursing services have undertaken 'mop up' of outstanding cohorts and programme will be up to date by end July 2022.
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Complete	January 2024 action complete as per Column D. Local CTS pathway developed incorporating All Wales pathway, GIRFT and BSSH guidance. Due implementation Feb/March 2024 with stakeholder engagement, primary care education sessions and audit plan in place. Aug 2023: Ongoing development of local CTS pathway in conjunction with RJAH and in line with GIRFT, BSSH and All Wales pathway. Delayed due to competing priorities but pathway completion aiming for end Sept 2023 with stakeholder engagement including primary care tofollow.We need to completed the CTS pathway work and then launch the pathway across all referrers. We are working through that at present. Anticipate a closure date of Dec 2023. Feb 2023: PTHB Carpal Tunnel Pathway under review with support from Hand & Wrist surgeon from Robert Jones Agnes Hunt NHS Trust who undertake largest volume of commissioned CTS procedures. Incorporating GIRFT/BHSS and WHC pathways into review. Anticipated pathway review completion end March 2023 including engagement with stakeholders across the pathway including, primary care, provider and commissioned services October 2022 Update Followed up with National AHP rep for WOB - other HBs still following existing pathways and no progression of discussions nationally to date. Decision to be made locally whether primary care position has now changed to facilitate implementation of the WOB endorsed CHS pathway in Powys, this could be facilitated through the changes arising from the Accelerated Cluster Development structure. June 2022 Update Still awaiting national discussion. March 2022 Update. Following submission of a development plan for this WHC, an implementation group was formed. Concerns were raised regarding the ability to embed the assessment measure advised within the WHC into primary care at such a busy time operationally and advice was sought from other HBs MSK leads to determine how this was being managed across Wales. Feed back was that there were concerns regarding the pathway and its implementation from most HBs and the AHP representative on the Welsh Orthopaedic Board agreed to take this back to the Board for discussion. Unfortunately, the meeting scheduled for February was postponed to March and has again been postponed to May meaning that it has not yet been discussed. Therefore whilst we have a development plan in place for this WHC, implementation has been paused whilst we await discussion at the WOB in relation to the national feed back.

2022 017	Wales Rare Diseases Action plan 2022-2026	16/06/2022	Health boards and NHS trusts, where appropriate, are asked to work with Welsh Health Specialised Services Committee (WHSSC), Rare Disease Implementation Group (RDIG), third sector and other relevant organisations to facilitate and implement the priorities and actions outlined in the Wales Rare Disease Action Plan. Health boards should take account of the priorities for rare diseases when planning their services and developing their Integrated Medium-Term Plans (IMTPs).	Medical Director	Ongoing	Complete	January 2024 The refreshed action plan for Wales and progress report for 2023/24 has been published. Action Plan 2022-26 refresh: Priority 1 - Helping patients get a final diagnosis faster Priority 2 - Increasing awareness of rare diseases amongst healthcare professionals Priority 3 - Better coordination of care Priority 4 - Improving access to specialist care, treatment and medicines Wales Rare Diseases Implementation Group, chairted by Medical Director of WHSSC, continue to meet quarterly to report on progress. This feeds into the UK Rare Diseases Framework Board. Next meeting 21 Feb 2024 (Katie and I members but membership is primarily service/operational). September 2023 - Wales part of UK wide work to design a UK Rare Diseases Framework. Rare Diseases Action plan (2022-26) developed by Welsh Government. PTHB taking this forward through its active participation in the WHSSC Joint Committee and WHSSC Management Group and as a member of the Rare Diseases Implementation Group. WHSSC Integrated Commissioning Plan 2023-24 references key actions in the delivery of the Rare Diseases Implementation Plan including: *Identifying and improving the pathway for patients with unknown or delayed diagnosis *Ensure better use of patient feedback, best practice and evidence to improve pathways for primary, secondary and specialist services. *Improve reporting of rare disease information including epidemiology, significant event analysis and shared learning. PTHB Integrated Plan 2023-24 details improvements to care co-ordination locally. Capacity challenges within PTHB previously highlighted remain. February 2023 Update remains unchanged from October 2022. We are hoping to ensure representation via the specialised service lead but this post is currently not yet in place. October 2022 Update PTHB does not provide any specialised services. It does not have the range of Clinical Directorates that would usually be involved in supporting and implementing this work in relation to Rare Diseases. The Planning and Performance Directorate attends the WHSSC Management Committee and the CEO attends the WHSSC Joint Committee. Through participation in the WHSSC Management Group and Joint Committee PTHB works to ensure that its Integrated Medium Term Plan reflects the approved WHSSC Integrated Commissioning Plan. PTHB does not have the capacity to take forward this work in a more detailed way. The health board is attempting to create a Specialised Pathway Lead post.
2022 023	Changes to the vaccine for the HPV immunisation programme	09/09/2022	Change to the vaccine schedule The Gardasil®9 vaccine will be provided for the following schedules of the HPV programme: • a one-dose schedule for the routine adolescent programme and MSM programme before the 25th birthday • a 2-dose schedule from the age of 25 in the MSM programme • a 3-dose schedule for individuals who are immunosuppressed and those known to be HIV-positive The UK Health Security Agency will continue to supply vaccine for the HPV programme in the usual way. It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year. Until the one dose schedule commences, the current 2 dose schedule will remain in place. Further communications will be issued once decisions have been made on the timing of the changes.	Director of Public Health	30/09/2024	Complete	January 2024 update: 1 dose schedule commencing in April 2024. SOP for vaccination session updated to reflect change. A New HPV toolkit has been released and is being promoted in schools. Update 17/10/2022: email sent 13/09/2022 from DPH to school health nursing (immunsation service leads)and Chief Pharmacist to inform of future changes and to action. Confirmation received from chief pharmacist is aware for PGD changes. No further action to take currently as the WHC states: 'It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year'.
2022 003	Guidance for the provision of continence containment products for Adults in Wales	21/10/2022	This document aims to outline national guidance to prevent variation and discrepancy in provision of containment products. It states that personalised care planning is a fundamental activity guiding best practice for the provision of containment products for adults in Wales. This is essential prior to identifying management options and consideration of the use of containment products. There is no statutory requirement to provide pad containment products if an individual does not fulfil the guidance for product provision.	Director of Nursing and Midwifery	31/10/2025	Complete	Update March 2024 - For adults,PTHB is compliant with the document.Due to increasing demand for a first line continence assessment the waiting list is now 12 weeks.We have a triage system in place to mitigate risks and a recent service review to address staffing requirements for the service to address the increasing workload is being actioned. Our triage system continues to address within 72 hours more timely requirements for end-of-life needs and our community teams have an allocated buffer supply of pads for sudden end of life deterioration as we require a 5-day lead time to supply routinely.There are no outstanding concerns regards this document at this time. The PTHB continence team were involved with the development of the adult document and will similarly be active in its review. We have Band 6 Continence Promotion Practitioners. Waiting list around 8 weeks. They assess patients and from their assessment pads may or may not be provided. We are an assessment/ treatment service and pads are provided on need and according to bladder and bowel dysfunction. We have a triage system for referrals so end of life patients for example are assessed and pads provided if required within 48 /72 hours. For children, the appropriate person assesses, e.g. children's nurse, school nurse etc and pads are then allocated again according to need.

2022 004	Guidance for the care of children and young people with continence problems	21/10/2022	The All Wales Continence Forum have undertaken work to review the All Wales Children and Young People's Continence Guidance and Care Pathway and have recommended that the current guidance should be replaced with the newly published 'Guidance for the provision of continence containment products to children and young people' (2021) thereby removing the discrepancy in the original guidance.	Director of Nursing and Midwifery	31/10/2022	Complete	Update March 2024:The service has completed the Paediatric Continence SOP which does incorporate the guidance.All requests for containment products (pads) are now reviewd via a weekly paediatric triage meeting(as per Paediatric Triage SOP).This process ensures that each child or young person has received the appropriate assessments,diagnostics and treatments according to their bladder and bowel dysfunction,from their appropriate service provider (including Health Visitors,School Nurses, Paediatric Specialist Services,etc).Only appropriate cases will be directed to the General Continence Service for pad acquisition,as per National/All Wales guidance. General continence eductaion and clinical supervision(including training in paediatric continence assessmnet/treatments) is currently being rolled out to school nursing service for a fixed three month period(Jan-March) through a Pathfinders initaitive.This project aims to digitally transform existing services and streamline caseload to increase Level 1 patient flow.It is expected that this re-modelling of level 1 Scool Nursing : Continence will be refelected in a new School Nursing: Continence SOP which is expected following completion of this project,at the end of March. The review of the list of trhe childrenin receipt of containment products against the guidance is ongoing,being highly dependent on caseload capacity through various universal and specialist services. Update September 2023:The service is completing the SOP which will incorporate the guidance – the deadline for completion has overrun but is expected for completion this quarter. The review of the list of the children in receipt of containment products against the guidance is outstanding this has been requested again as a priority for completion this quarter.
2023/018	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies	14/06/2023	Notifying NHS Wales bodies of the requirements to adopt HL7 FHIR as a foundational standard for interoperability and advise of the need for compliance from May 2023.	Director of Finance and IT	Immediate	Complete	The Data Architecture (which has been in place since April 2023) is FHIR compliant. We are continually working with DHCW to ensure any developments of FHIR from a National perspective are reflected into our Architecture. We also have a presence on relevant National groups to ensure collaboration in future FHIR designs. Any system procurement within PTHB now is also being done so with FHIR as the default where appropriate. The renewed Data Architecture for PTHB has been designed to be FHIR comlaint.This Platform went live in April 2023.Continuing developments are on-going to enhance this functionality in-line with the National Data Resource Programme.
2023/023	The National Influenza Vaccination Programme 2023-24	22/06/2023	Detailed guidance for the flu vaccination programme for the coming autumn and winter (Natinal Influenza Immunisation Programme 2023/24) is set out at Annex 1. NHS organisations should be focussed on the ambitions outlined in the National Immunisation Framework (NIF) for Wales as they develop plans to delivery the programme described in this circular. The WHC outlines eligible groups for 2023-24, in addition, individuals experiencing homelessness will also be an eligible group in 2023/24. Further detail on the eligible groups is contained within Annex 2. WHC also provides information in relation to "Otherwise healthy 50-64 year olds", "Maximising uptake and ensuring equity" and "Winter Respiratory Vaccination Programme".	Director of Public Health	31/03/2024	Complete	Update January 2024: superseded by WHC 2023/029. Preparatory work in progress including development of a delivery plan and supporting communication campaign.
2023/022	Armed Forces Covenant – Healthcare Priority / Special Consideration for Veterans / Ex Armed Forces Personnel	26/06/2023	This circular is to update and clarify guidance on Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41). It reaffirms the Armed Forces Covenant commitment to provide priority treatment for veterans suffering from health conditions considered to be directly related to their Service	Director of Public Health	30/06/2026	Complete	August 2023 update - Powys Armed and Ex Forces Health Forum re-established; action plan developed and being implemented.
2023/024	Change of Vaccine and cohort expansion for Shingles Vaccination Programme	28/06/2023	In line with other vaccination programmes, health boards are responsible for commissioning vaccination services and will need to assure themselves on the delivery and uptake of their programme. Arrangements have been put in place to enable health boards to commission General Practices to deliver programmes locally. Health boards will wish to reflect the expectations outlined in this circular in their commissioning arrangements.	Director of Public Health	31/08/2028	Complete	January 2024 update: GPs are implementing their plans to roll out the programme. August 2023 update: Engagement has commenced with GPs who are developing and starting to implement their plans to comply with the circular.
2023/010	Certification of Vision Impairment in Primary and Community Care		Accordingly, a new All Wales patient pathway will be introduced that will enable patients to be certified as visually impaired by Wales Eye Care Services (WECS) optometrists who are low vision accredited and have completed an approved training module as determined by Health Education and Improvement Wales (HEIW) and outlined in WECS Standard Operating Procedures. This will be in addition to Consultant Ophthalmologists certifying patients. This new approach aligns to the principles of prudent healthcare and our commitments in A Healthier Wales and the Future Approach for Optometry Services. (NB Prior to optometry contract reform, the accreditation required is Eye Health Examination Wales (EHEW) plus Low Vision Service Wales). Four changes have been made to the existing Certification of Vision Impairment Wales (CVIW) form to accommodate this: • The heading "To be completed by the Ophthalmologist (tick one)" changed to "To be completed by the Ophthalmologist/Optometrist (tick one)", • Inclusion of tick boxes to indicate whether the practitioner is an ophthalmologist or optometrist, • Inclusion of tick boxes to indicate whether certification was performed within the hospital eye service, an optometry practice or a mobile setting • The label "Hospital address" changed to "Certifiers primary hospital/optometry practice address" The same CVIW 2022 form will be used for certification in primary and community care and in secondary care. The patient pathway for this service can be found in the relevant clinical manuals	Director of Finance and IT	30/05/2023	Complete	All Powys Optometry practices are EHEW accredited.Once CVI is formally approved via Contact Reform it will be implemented across the health board. 1/02/24 - CVI process published in WGOS manual in conjunction with Low Vision and shared with profession. Optometrist now able to issue the certificates for dry AMD
2023 026	NHS Research and Development Framework	28/07/2023	I expect NHS organisations to use the framework to develop robust plans for the future, working collaboratively with a range of partners, for instance, Health and Care Research Wales, higher education providers, research agencies and funders, third sector organisations, life science companies and the public.	Medical Director	Immediate	Complete	January 2024 Self assessment against NHS R&D Framework Completed. We comply with the areas of the framework that relate to PTHB 11.08.2023 A number of the elements sitting within the 10 pillars described in this WHC are complete. We are undertakeing a self assessment agains the 10 pillars in preperation for our perfomance review with HCRW in December. This self assessment will be completed by mid September.

2023 029	Winter Respiratory Vaccination Programme: Autumn and Winter 2023 to 2024	17/08/2023	Last autumn the first Winter Respiratory Vaccination Programme for Wales was delivered by bringing together the COVID-19 and influenza (flu) vaccination programmes. This enabled health boards to coordinate the planning of both programmes and, where possible, to streamline delivery. It also enabled an improved experience for patients. Over 1.1 million people received a COVID-19 booster and over one million flu vaccines were administered over the course of the programme. To build on that success, in 2023/24 the National Influenza Immunisation Programme and the COVID-19 Vaccination Programme will again be brought together to form a single Winter Respiratory Vaccination Programme (WRVP 2023/24). This programme will be underpinned by the key principles: - Protecting those at greatest risk - Protecting children and young people - Protecting frontline health and social care workers - Protecting the NHS To implement the WRVP 2023/24 effectively, health boards should develop plans for a single, coordinated and coherent programme for both vaccines. Wherever possible, delivery models should be aligned to allow for co administration, to help maximise efficiencies and reduce vaccination inequity.	Director of Public Health/Chief Executive Officer	N/A	Complete	Delivery plan developed and implemented.
2023 033	Vaccine Products to be used in the Autumn 2023 COVID-19 Vaccination programme	01/09/2023	Further to WHC (2023) 029, I am writing to confirm the COVID-19 vaccine products to be deployed in Wales this winter. I am also providing you with revised instructions on the sequencing of offering vaccination to eligible groups in response to the emergence of a new COVID-19 variant. Colleagues will be aware of the recent identification of a new variant (BA.2.86). While there is currently a great deal of uncertainty surrounding this new variant, there is clinical consensus across the UK nations that precautionary measures need to be considered. Clearly, our COVID-19 vaccination programme is a critical element of this.	Director of Public Health/Chief Executive Officer/Medical Director/Director of Primary Care/Director of Workforce and OD	N/A	Complete	Appropriate actions undertaken to realign plans with WHC.
2023 034	NHS Welsh Sustainability Awards	25/09/2023	Please can all colleagues copied into this Welsh Health Circular cascade and promote the NHS Welsh Sustainability Conference and Awards information below, through their staff networks and communications channels. The NHS Welsh Sustainability Conference and Awards • Dedicated NHS colleagues have established and launched the NHS Welsh Sustainability Conference and Awards to promote the principles of sustainable healthcare and support the incorporation of sustainable practices into clinical care. • The NHS Welsh Sustainability Conference and Awards event will be held on 29th February 2024 at The Vale Hotel, Cardiff. • The Conference - You are invited to 'Save the Date' and join an immersive day of exhibition and key-note speakers focussing on clinical care, carbon hotspots in your service and sustainable value. • The Awards – Why not get involved? Submit a sustainability project to one of the nine awards categories before 31st January 2024 to have the opportunity to join this exclusive event. Read the event guidance an	Director of Finace,Information and IT, Medical Director,Chief Executive Officer,Director of Therapies and Health Sciences,Director of Workforce and Organisational Development	N/A	Complete	March 2024 update:Shared with heads of therapies and health sciences to dissenminate amongst their staff
2023 037	Patient Testing Framework for Autumn / Winter 23	26/09/2023	Following a significant reduction in regular testing over spring and summer, we have reviewed testing guidelines for autumn and winter. While COVID-19 and flu seasons remain hard to predict, public health advice suggests: • It is most likely that there will be a peak in prevalence of SARS-CoV-2 infection during the winter season, but associated COVID disease will remain relatively mild. • There is no indication that there will be a bad influenza season in 2023/24. • There is no indication that there will be a bad RSV season in 2023. The level of hospital activity over the winter will depend to an extent on vaccine booster uptake in vulnerable groups as well as the emergence of new variants.	Director of Public Health/Medical director	31/12/2023	Complete	January 2024 completed by PH andIPC team/expired.
2023/038	Healthy Start eLearning course	09/11/2023	It will be mandatory for all health care professionals working with pregnant women and families with children under 4 years old. This will include staff within Flying Start, Child and Adolescent Mental Health Services, those working in children's centres, healthcare support workers, community nursery nurses, assistant practitioners, and Allied Health Professionals. It will need to be retaken every 3 years, or sooner if there are significant changes to the scheme. It should be introduced as part of the induction process for new employees who have not already undertaken the training and for those already in post, they should be informed that they will need to complete i	Director of Public Health/Director of Workforce and OD	Immediate	Complete	Communication with PTHB staff undertaken to promote elearning module.
2023/044	Influenza (flu) Vaccination Programme deployment 'mop up' 2023- 2024	11/12/2023	Influenza (flu) vaccination remains one of the most effective public health interventions to protect people against infection and reduce pressure on health and social care services over the busy winter period. I am therefore concerned that vaccine uptake in the current programme is below the Welsh Government target of 75% across all eligible adult groups. Unless we take steps to address this, there is the potential for this to have significant consequences for the health of people at higher risk from COVID-19 and flu and for our health and social care services later in what we're all expecting to be a challenging winter. It is imperative that we take action.	Medical Director/Director of Finance,Information and IT/Directors of Public Health	N/A	Complete	This one has been implemented in January in line with WHC requirments – so complete

2023/043	Vaccination of Healthcare Staff to Protect Against Measles	14/12/2023	Considering staff members who are not fully protected could be excluded from the workplace for up to 21 days following exposure, I would ask the following: • By 31 January 2024, health boards audit staff MMR vaccination / recorded natural immunity to measles, as part of a risk assessment of all high-risk areas, including A&E and Paediatric. • Undertake any identified mitigating actions, including providing a locally agreed route to vaccination. • Primary Care providers risk assess the impact of their staff MMR vaccination / recorded natural immunity to measles, and escalate to their health board any risk which cannot be mitigated to an acceptable level.	Chief Executive Officer,Medical Directors,Director of Public Health,Director of Workforce and Organisational Development,Director of Therapies and Health Sciences	31/01/2024	Complete	March 2024 update:Actions undertaken by Occupational Health and Primary Care in line with WHC requirements. March 2024 update:Shared with heads of service in therapies and health sciences for information and to disseminate with staff.
2023/047	Influenza Vaccines and Eligible Cohorts for the 2024/25 season.	21/12/2023	This Welsh Health Circular is being published to confirm: • eligible cohorts for the 2024/25 influenza (flu) season • reimbursable vaccines for the 2024/25 flu season • changes to the start of the 2024/25 adult flu vaccination programme (except for pregnant women). This information is being issued at this time to enable plans for the delivery of next year's flu vaccination programme to be put in place. A well-planned and executed programme which results in the timely delivery of vaccination is vital to ensuring the eligible population is protected before flu activity starts to increase during the winter months. A further circular will be issued at the earliest possible opportunity with more detailed operational guidance and expectations for the 2024/25 Winter Respiratory Vaccination Programme, which includes the flu programme alongside the COVID-19 programme on which Joint Committee on Vaccination and Immunisation (JCVI) is yet to advise.	Chief Executive Officer/Medical Director/Director of Primary Care/Director of Therapies and Health Science/Director of Public Health/Director of Workforce and Organisational Development	N/A	Complete	29/12/23 Sent out to practices by PTHB Imms Team and also circaulted by SSP. Information disseminated to Primary care/GPs/Pharmacies
2024/001	Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests and Covid-19 treatments.	10/01/2024	Testing will continue where clinically indicated in secondary care settings. There will be no change to the way Health Boards order their lateral flow tests for clinical use. These should continue to be ordered through NWSSP via the Oracle ordering system. Guidance on respiratory viruses including Covid-19 for staff in health, social care and special schools can be found here. Current advice and guidance on Covid-19 testing and Covid-19 antiviral treatment on Welsh Government's web pages will be updated from 1 February to reflect the changes detailed within this circular.	Director of Public Health	N/A	Complete	Plans align with WHC.
2022 009	Prioritisation of COVID-19 patient episodes by NHS Wales Clinical Coding Departments	01/04/2022	Due to the need for COVID-19 information to be as real-time as possible all NHS Wales Clinical Coding departments are asked to ensure that processes are put in place as soon as possible to ensure the following: ⍰ All FCEs for patients with COVID-19 are identified upon discharge and prioritised by the Local Health Board/NHS Trust for the assignment of codes ⍰ Such episodes of care are coded within the first week following discharge to allow for an accurate view of COVID-19 inpatient data on a weekly basis ⍰ Each Local Health Board and NHS Trust to report their current numbers and percentages of uncoded COVID-19 and non COVID-19 episodes to Welsh Government (HSS.Performance@gov.wales) on the last day of each month.	Director of Finance and IT	28/02/2023	Complete	February 2024 update:This requirement was withdrawn in August,so there is no outstanding action.
2023/035	UPDATE OF GUIDANCE ON CLEARANCE AND MANAGEMENT OF HEALTHCARE WORKERS LIVING WITH A BLOODBORNE VIRUS (BBV) AND A REMINDER OF HEALTH CLEARANCE FOR TUBERCULOSIS.	01/10/2023	Further to WHC/2019/023 issued in July 2019, we are writing to inform you that the guidance on the clearance and management of healthcare workers (HCWs) living with a bloodborne virus (BBV), has been updated. We would also like to draw your attention to, and remind you of, the importance of adhering to the guidance relating to health clearance checks for Tuberculosis (TB). Integrated Integrated guidance on health clearance of healthcare workers and the management of healthcare workers living with bloodborne viruses (hepatitis B, hepatitis C and HIV	Chief Executive Officer/Medical Director/Director of Nursing/Director of Workforce/Director of Public Health	Immediately	Complete	The Occupational Immunisation Policy has been amended to align with Welsh Health Circular .The only addition required, was to sign-post the reader to the new guidelines published by the UK Health Security Agency.
Ministerial Directions:							
23-26 MD2	Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) Wales) (No. 2) (Amendment) Directions 2023.	27/07/2023	The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed (1) 2006 c. 42. 2 Enhanced Service) (Wales) (No. 2) Directions 2021 are amended as follows. (2) In Direction 4(4)(b)(i)(aa) for "aged 50" substitute "aged 65".	Director of Finance and IT /Director of Public Health	01/09/2023	Complete	01/08/23 guidance was issued to all GP practices before commencement of 23/24 flu campaign. Issued by SSP All Wales Alert and Primary Care Department. All practices are aware of the change in the age criteria.
23-27 MD1	The Nursery Milk Scheme (Wales) (Amendment) Directions 2023	20/07/2023	(1) The Nursery Milk Scheme (Wales) Directions 2022(1) are amended as follows. (2) In paragraph 9(1) for "31 July 2023" substitute "31 July 2025"	Director of Public Health	31/07/2023	Complete	This can be marked as closed as it's an amendment to the 'Title' of the scheme and direction to Business Services to amend.
23-42 MD1	The Primary Care (Contracted Services: Immunisations) (Amendment) Directions 2023	23/08/2023	(1) The Primary Care (Contracted Services: Immunisations) Directions 2021(2) are amended as follows. (2) In Direction 4 (Primary Care Contracted Services: Immunisations Scheme) for paragraph (4)(e) substitute— "(e) payment arrangements for an engaged provider which must provide for it to be able to claim, in accordance with paragraph 7 of the Covid-19 Vaccines Specification, a payment of £10.03.". (3) In Schedule 1 (Primary Care Contracted Services: Immunisations (Covid-19 Vaccines) Specification) for paragraph 7(a) (Payment for administration of a Covid-19 vaccine under this PCCS:I) substitute— "(a) The Local Health Board must pay to an engaged provider who qualifies for the payment in accordance with Directions 5 to 7, a payment of £10.03 in respect of each dose of a Covid-19 vaccine administered to a person under this PCCS:I.".	Director of Finance,Information and IT	25/08/2023	Complete	21st August Updated price change shared with Practices by Public Health Team. PCCIS specification shared with practices, issued by SSP 23/08/23

WG23-47	The National Health Service (Wales Eye Care Services) (Wales) Directions 2023.	20/10/2023	2.—(1) The Eye Health Examination Service Committee (Wales) Directions 2016(3) are amended as follows. In direction 1(3) (Title, commencement and application), after “Local Health Boards and” insert “Velindre University NHS Trust and”. (3) In direction 2 (Interpretation)— (a) omit the definition of “Eye Health Examination Clinical Lead”; (b) omit the definition of “Eye Health Examination Service Accredited Practitioner”; (c) omit the definition of “Eye Health Examination Service Manager”; (d) omit the definition of “Eye Health Examination Service team”; (e) omit the definition of “host Local Health Board”; (f) in the definition of “Local Health Board” after “Act” omit “(2)”; (g) in the definition of “the joint committee”, for “Eye Health Examination Service” substitute “Enhanced Optometry Services”; (h) for the definition of “the relevant functions” substitute— ““the relevant functions” means arranging the provision of the Enhanced Optometry Services;”;	Director of Finance,Information and IT	20/10/2023	Complete	October 2023 update:Pause for now due to the new regulations.awaiting updates February 2024 update: Directions circulated to all contractor via SSP distribution
1MD	The Eye Health Examination Service Committee (Wales) Directions 2016.	05/04/2016	(1) The Local Health Boards will jointly exercise the relevant functions. (2) For the purpose of exercising the relevant functions the Local Health Boards will establish a joint committee as soon as practicable after 5 April 2016. (3) The host Local Health Board will exercise its functions to provide administrative support for the running of the joint committee and establish the Eye Health Examination Service team. (4)(3) The joint committee will ensure that the relevant functions are exercised in accordance with the service specification in Schedule 1 to these Directions.	Director of Finance,Information and IT	N/A	Complete	October 2023 update:Pause for now due to the new regulations.awaiting updates Feb 2024: amended in line with contract reform and associated regulatory changes
1MD	The Low Vision Service Committee (Wales) Directions 2016.	05/04/2016	1) The Local Health Boards will jointly exercise the relevant functions. (2) For the purpose of exercising the relevant functions the Local Health Boards will establish a joint committee as soon as practicable after 6 April 2016. (3) The host Local Health Board will exercise its functions to provide administrative support for the running of the joint committee and establish the Low Vision Services team. (4)(3) The joint committee will ensure that the relevant functions are exercised in accordance with the service specification in Schedule 1 to these Directions.	Director of Finance,Information and IT	N/A	Complete	Feb 2024: amended in line with contract reform and associated regulatory changes

BOARD ASSURANCE FRAMEWORK	Agenda Item 3.6
Subject:	Board Assurance Framework (BAF)
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Author:	Director of Corporate Governance/Board Secretary
Purpose:	This presentation provides a summary of the approach being taken to develop the Board Assurance Framework (BAF) for Powys Teaching Health Board, due to be presented to the Board in May 2024.
Recommendations:	The Committee is asked to: • **RECEIVE** the presentation and offer any observations or comments to aid the development.

What is a BAF?

- ‘An (Board) assurance framework is a **structured means of identifying and mapping the main sources of assurance** in an organisation, and co-ordinating them to best effect’.
- The most effective Boards use this as a **dynamic tool to drive the Board agenda**. Formats vary but the framework generally includes:
    - Objective
    - Principal risk
    - Key controls
    - Sources of assurance
    - Gaps in control/assurance
    - Action plans for addressing gaps.
- The assurance mapping process and the way of illustrating the results using a BAF can give confidence to management and the board that they ‘**really know what they think they know**’.

Purpose of the BAF

- Help the board to **consider collectively** the process of securing assurance that promotes good organisational governance and accountability, including:
  - Gaining a **clear and complete understanding of the risks faced by the organisation** in the pursuit of its strategic objectives, the types of assurance currently obtained, and consideration as to whether they are effective and efficient;
  - Identifying areas where **assurance activities are not present**, or are insufficient for our needs (assurance gaps);
  - Identifying areas where **assurance is duplicated**, or is **disproportionate** to the risk of the activity being undertaken (i.e. there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resource);
  - Identifying areas where **existing controls are failing** and as a consequence the risks that are more likely to occur;
  - The ability to better **focus existing assurance resources**; and
  - Providing an evidence base to assist the organisation in the preparation of its **annual governance statement**.

Board Assurance Framework

(Sources of Assurance in relation to the achievement of Health Board's Strategic Objectives)

Powys Health and Care Strategy

Integrated Medium-Term Plan

Annual Delivery Plan

Strategic Objectives

Corporate Risk Register

Risks that represent a threat to achieving the Health Board's strategic objectives

Governance Framework / Arrangements

Standing Orders, Standing Financial Instructions, Committee's of the Board, Terms of Reference, Work Programmes

Internal Sources of Assurance
(Based on Three Lines Model, IIA)

First Line (Management Oversight):

Second Line (Corporate Oversight):

Third Line (Internal Audit):

- Internal audit
- External audit

External Sources of Assurance (External Audit, Health Inspectorate Wales, Welsh Government, Stakeholder Engagement)

Organisational Culture and Values including High Performing Board

Key Components of the Governance Framework

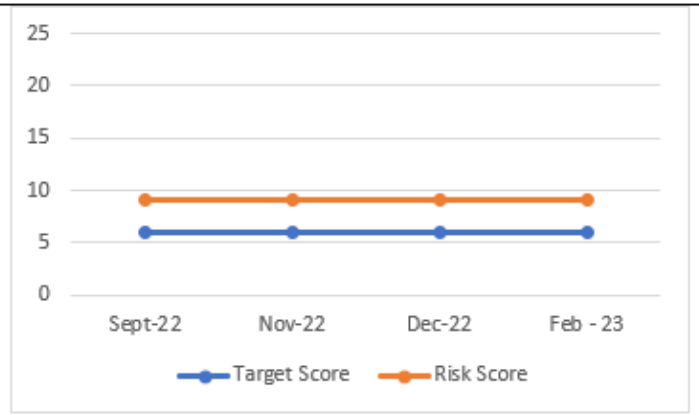
Development of the Corporate Risk Register – levels of assurance

CRR 007 **Risk that:** ineffective partnership working, including on service change/reconfiguration, results in poorer outcomes and experience for citizens of Powys	**Executive Lead:** Director of Planning and Performance **Assuring Committee:** Planning, Partnerships and Population Health
Risk Impacts on: Organisational Priorities underpinning WBO 8	**Date last reviewed:** February 2023

Risk Rating

(likelihood x impact):
Inherent: 3 x 4 = 12
Current:3 x 3= 9
Target: 2 x 3 = 6

Date added to the risk register
Risk Updated September 2022



Rationale for current score:

- Effective partnership working arrangements requires strong governance and performance management. There should be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population. In January 2021, Internal Audit reported limited assurance in respect of how the Health Board ensures effective partnership governance.
- Further, achievement of the health board's Health and Care Strategy will be dependent on the success of successful working relationships with key partners and stakeholders.

	Controls (What are we currently doing about the risk?)	Sources of Assurance	Level of Assurance
7.1	▪ Health Board attendance at Public Service Board, Regional Partnership Board, Joint Partnership Board	• Meetings Agendas and Minutes	Limited
7.2	▪ High-level reporting to Board from Public Service Board, Regional Partnership Board, Joint Partnership Board	• Board Reports • Meeting Agendas and Minutes	Reasonable
7.3	▪ Powys Health and Care Strategy in place with Powys County Council and PAVO	• Integrated Medium-Term Plan Reporting • Joint Board/Cabinet Meeting Agenda/Minutes	Substantial
7.4	▪ Active engagement with Mid Wales Joint Committee	• Meeting Agendas and Minutes • Reporting to Board	Reasonable

High
Full assurance provided over the effectiveness of controls.

Medium
Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve.

Low
Assurance indicates poor effectiveness of controls.

What does the BAF look like / how do we present it

- High level dashboard summarising/rating the headline / key components – report to each Board
  - More detailed dashboards for each component – reported to Committees
- Corporate risk register becomes an integrated part of the BAF and has a
  - High level overview of risks, risk scores and assurance levels including a heatmap – report to each Board
  - More detailed copy of each CRR including controls, actions - reported to Committees
- Action plan – summarising the key developments agreed by the Board to improve the Board required assurances

Other areas to consider

- Board agenda – presentation and positioning
- Role of the Board
- Role of Committees
- Approach to prioritising committee work plans – may need to be agile
- Frequency of assurance mapping – some likely to be annual (e.g. governance framework)
    - Enhance third line and external challenge into the process?
- Patient voice
- Triangulation of information – more meaningful analysis
- Directorate level assurance frameworks

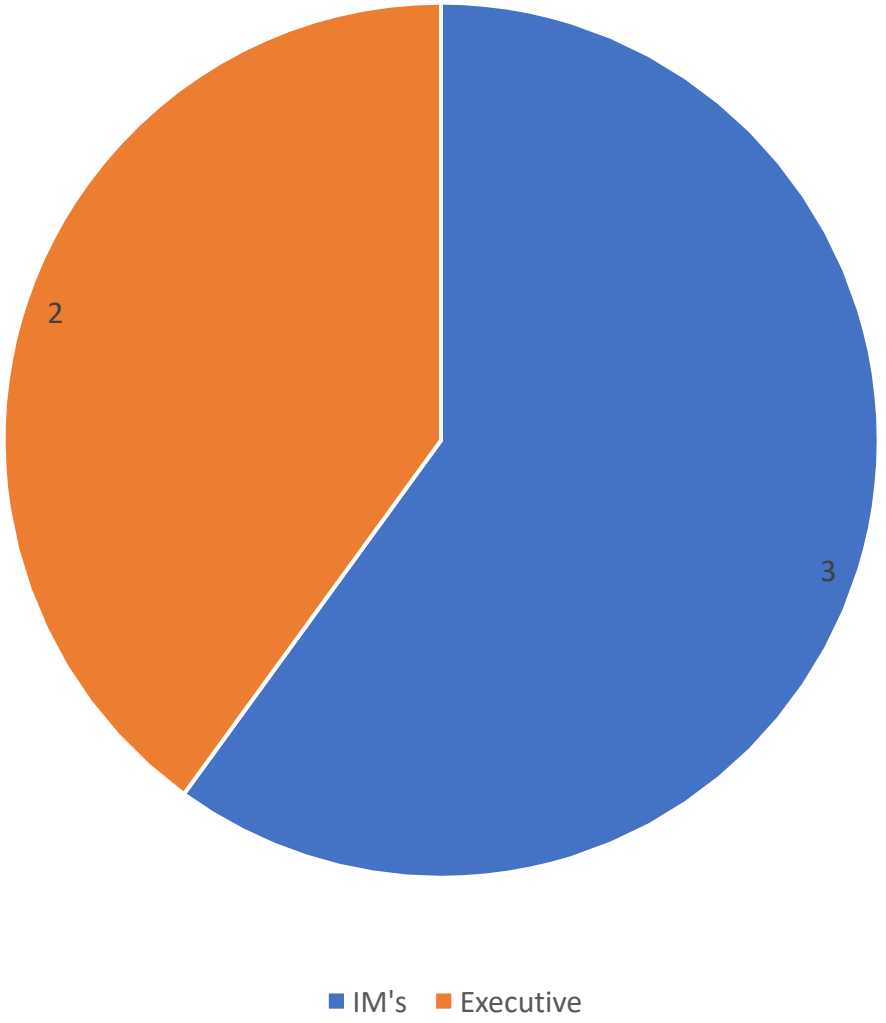
Next Steps

- New corporate risks to directly relate to the delivery of the strategic priorities
- Board Development – April
- Present final model to Board – May
- Implement for 2024/25 onwards
- Develop further into 2024/25 onwards

Audit and Risk Assurance Committee – 29 February 2024	Agenda Item xx

Subject:	Committee Effectiveness – Audit and Risk Assurance Committee
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Author:	Director of Corporate Governance/Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire (ARAC); and is provided to stimulate discussion within the Committee to support the identification of what works well, learning and actions for improvement.
Recommendations:	The Committee is asked to: • **DISCUSS** the summary of the Committee Effectiveness survey and any areas for action/improvement.
Executive Summary:	Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous improvement. The approach for 2023/24 contained a questionnaire and then discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, and (iii) assurance.

Response Overview



Mills Belinda
11/03/2024 17:12:59

Section 2 – Composition and Establishment

Overview of ratings – Composition and Establishment

Question	Lowest score	Highest score	Score as % of maximum
The Committee understands its role	3	4	90%
The Committee annual work plan covers all the relevant areas in terms of reference.	3	4	95%
The Committee has the membership, authority and resources to perform its role effectively.	4	4	100%
The right people attend meetings of the Committee to enable it to fulfil its role effectively.	4	4	100%
Committee members have the collective skills & experience needed to fulfil the terms of reference and to advise & assure the Board.	3	4	85%

Effective Functioning – Composition and Establishment

- Clarity on 'nose in hands out', especially upon receiving final internal audit reports, would be helpful.
- Finance IM appointment in pipeline and to be welcomed
- This is a useful and effective committee and is very efficient in dealing with the agenda it addresses
- The committee will be improved further when all IM posts are filled.

Section 3 – Effective Functioning

Overview of ratings – Effective Functioning

3	Lowest score	Highest score	Score as % of maximum
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge.	3	4	95%
Committee meetings are conducted in a business - like manner and managed effectively with issues getting the time & attention proportionate to importance.	4	4	100%
Committee papers are of good quality and provide sufficient information (detail, presentation, timeliness) to enable the committee to fulfil its role.	4	4	100%
There is good monitoring of matters arising & agreed actions to support the Committee in its role.	3	4	95%

Overview of ratings – Effective Functioning

Question	Lowest score	Highest score	Score as % of maximum
The Committee is briefed on urgent/emerging issues (policy, performance or new legal/regulatory obligations) in a timely and appropriate way.	3	4	90%
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues.	3	4	95%
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, issues escalated, sharing of good practice).	3	4	95%
In meetings, we listen to and respect each other's views.	4	4	100%

Effective Functioning – Comments

- Meetings are effectively chaired
- Committee is well run and focused.

Section 4 – Assurance

Overview of ratings – Assurance

Question	Lowest score	Highest score	Score as % of maximum
The Committee receives sufficient and timely reports and advice on key issues that clearly set out the analysis of the situation, the risks and the assurance the Committee can take in order to enable it to discharge its responsibilities.	3	4	18
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance.	4	4	100%
The Committee receives regular and sufficient evidence that the organisation is learning and improving.	3	3	75%
Performance reporting is at an appropriate level to enable the Committee to identify areas where it requires further assurance.	4	4	100%
The Committee receives the assurance it needs to fulfil its role effectively.	4	4	100%

Assurance – Comments

- 'Learning organisation'. Link to our reaction and degree of intervention in regards to Audit here.

Section 5 – General Comments

Comments - What areas are going well?

- The committee translates some dry and apparently limited value info into things of greater value.
- I have only covered for IM's but have found the papers and the way the committee is conducted makes it easy to get up to speed and contribute
- Excellent chairing, timely reports and well presented by Executive members and staff
- Willingness to engage with the agenda and challenges
- Well organised, agenda focus and good questions re assurance.

Comments – What could be Improved?

- I think that the briefs of internal audit are critical to those audits being successful and 'hitting the spot'. It is not possible to remedy this retrospectively. More attention must be given to the Committee involvement in the brief.
- Volume of papers - can be a challenge - summary of key issues may help
- Sometimes time spent re individual audit reports can be too long when not a material issue.

Comments – What training/other development activity would support the Committee in its role?

- Ongoing training on a refresh basis as already provided.

Comments – What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?

- Primary Care
- Effectiveness of the spend of budgets and the risk to services being provided to patients - checking that savings in the short term don't lead to a higher cost longer term
- I think the agenda has the right focus re risk and governance issues.

Any Other Comments

- No further comments made

Next Steps

Next Steps

Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	11 March 2024
2. Receive feedback from the Committee, discuss any actions / improvements	11 March 2024
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (May 2024)
4. Committee feedback and key actions will be incorporated into summary report with other Committees' feedback and shared with the Board	By end May 2024
5. Committee forward plan for 2024/25 is in development and will form part of the April Committee meeting (reviewed at each meeting)	Next Committee meeting (May 2024)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

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

Audit, Risk and Assurance Committee

Terms of Reference & Operating Arrangements

September 2021

1. INTRODUCTION

1.1 Section 2 of Powys Teaching Health Board's (referred to in this document as 'PTHB' or the 'health board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

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

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk managements

arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

✓ work performed (and a comparison with work planned);
✓ key issues emerging from the work of internal audit;
✓ management response to audit recommendations;
✓ changes to the agreed internal audit plan; and
✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;
  - extensions of contracts:
  - writing off of losses; or
  - the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;

- the internal audit strategy;

- the Head of Internal Audit's Annual Opinion and Report;

- quality assurance reports on the internal audit function;

- the draft accounts of the organisation;

- the draft Annual Accountability Report which includes the Annual Governance Statement;

- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 3
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance and IT
- Board Secretary

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Board Secretary.

Member Appointments

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

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

4.9 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held no less than quarterly and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance

with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

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

7.3 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Issue of Committee papers

8.2 The Board and Board Committee Handbook provides detailed

guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.2

Audit, Risk and Assurance Committee	**Date of Meeting: 11 March 2024**
Subject :	**Audit and Risk Assurance Committee Terms of Reference**
Approved and Presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Liz Patterson, Interim Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:
The purpose of this paper is for the Committee to consider the Terms of Reference of the Audit, Risk and Assurance Committee in order to ensure that they remain fit for purpose.
RECOMMENDATION(S):
The Committee is asked to: • **IDENTIFY** any suggested amendments to the Committee terms of reference in order to make recommendations to the Board in May 2024. • **AGREE** that the Chair of the Committee and Director of Corporate Governance finalise any recommendations to the Board.

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

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

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

EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis. The existing Terms of Reference (Sept 2021) for the Delivery and Performance Committee are attached as Appendix 1.

Any suggested changes will need to be recommended to the Board for approval.

The Committee is asked to discuss the current terms of reference and identify any suggested amendments. The Chair of the Committee and Director of Corporate Governance will then take forwards any recommendations to the Board in May 2024 to take effect into 2024/25.

It is suggested that the Committee specifically considers:

Section of Terms of Reference	Comment / Suggestions
2 - Purpose	Does this remain accurate and appropriate?
3 - Delegated Powers and Authority	Does this remain accurate and appropriate?

	It is proposed that *compliance with Health and Safety Regulations and Fire Safety Standards* be moved to Workforce and Culture Committee.
5 - Committee meetings	• The modern practice of holding meetings virtually should be reflected. • The ability to take any decisions via Chair's Action (where appropriate) should be added • Proposed change to wording to be x4 meetings per year instead of no less than quarterly
Tidying up	The document requires some general tidying up to ensure correct job titles are reflected

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forwards any recommendations to the Board in May 2024 to take effect into 2024/25.

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

IMPACT ASSESSMENT - ASSESSMENT NOT REQUIRED					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age	x				
Disability	X				
Gender reassignment	X				
Pregnancy and maternity	X				
Race	X				
Religion/ Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and civil partnership	X				
Welsh Language	X				
Risk Assessment:					
	Level of risk identified				**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
	None	**Low**	**Moderate**	**High**	
Clinical	X				
Financial	X				
Corporate	X				
Operational	X				
Reputational	X				

Audit, Risk and Assurance Committees 2023-24

Theme	Item Title	TBC July Accounts	May 16/05/2023	July 11/07/2023	Oct 10/10/2023	Jan 16/01/2024	March 12/03/2024	Comments
Governance	Minutes of previous meeting	✓	✓	✓	✓	✓	✓	
Governance	Declaration of Interests					✓	✓	
Governance	Action Log	✓		✓	✓	✓	✓	
Governance	Annual Work Programme	✓						To May ARAC
Governance	Work Programme (updated through year)			✓	✓	✓	✓	
Governance	Annual Assessment of Committee Effectiveness	✓					✓	
Governance	Committee Annual Report	✓						
Governance	Annual Governance Programme	✓			☒	☒	☒	AGP integrated into Annual Delivery Plan
Governance	Audit Recommendation Tracker	✓			☒	✓	✓	
Governance	Audit Recommendation Tracker (Deep Dive)					✓		
Governance	WHC Tracker	✓			✓		✓	
Governance	Register of Interests			✓		✓		
Governance	Register of Gifts and Hospitality				✓	✓		
Governance	Raising Concerns/Speaking Up (was Whistleblowing Report)				☒	☒	☒	Scheduled to Board in May, was also considered in a joint PEQs/W&C Committee in October 2023
Governance	Review of Terms of Reference						✓	
Governance	Review of Standing Orders						☒	Scheduled to May ARAC
Governance	Confirmation Clinical Audit Programme in place			✓				
Governance	Board Assurance Framework						✓	
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	✓		✓				
Annual Accounts	Charitable Funds - annual accounts and report							Will be managed through CF Cttee and direct to Board due to known Audit implications
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	✓		✓	✓	✓		
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	✓		✓	✓	✓	✓	
Finance and Procurement	Losses and Special Payments Annual Report	✓						
Finance and Procurement	Losses and Special Payments				✓		☒	To May meeting of ARAC as report will cover to the year end
Finance and Procurement	Post payment Verification Workplan						☒	To May meeting of ARAC as report will cover to the year end
Finance and Procurement	Post payment Verification update				✓			
Risk	Review of Risk Management Framework				✓			

Risk	Review of Risk Management arrangements				✓			
Hosted Bodies	Hosted Body annual report (HCRW)							
Internal Audit	Internal Audit - Themes Reflections Paper					✓		
	Provision of Orthodontic Treatment STW					✓		
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								

Mills Belinda
11/03/2024 17:12:59