Audit, Risk and Assurance Committee

Tue 16 January 2024, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARAC_Agenda_16Jan24.pdf (3 pages)

1.1. Welcome and Apologies

Chair

1.2. Declarations of Interest

All

1.3. Minutes from the previous meeting held on 10 October 2023 for approval

Attached *Chair*

ARAC_1.3_Unconfirmed_Minutes_10 October 2023.pdf (12 pages)

1.4. Committee Action Log

Attached *Chair*

ARAC_1.4_Action Log Jan24.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver including re provision of Orthodontic Treatment

Attached *Director of Finance, Information and IT*

ARAC_2.1_Application for Single Tender Waiver Jan 24.pdf (3 pages)

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Internal Audit Progress Report 2023-24

Attached *Head of Internal Audit*

ARAC_3.1_ Internal Audit Progress Report January 24 Cover.pdf (4 pages)
ARAC_3.1a_ Internal Audit Progress Report January 24.pdf (13 pages)

3.2. Internal Audit Reports:

Attached *Head of Internal Audit*

3.2.1. Business Continuity Planning Final Internal Audit Report (Substantial Assurance)

ARAC_3.2a_ Business Continuity Planning_Final Internal Audit Report.pdf (11 pages)

3.2.2. Clinical Education-HSCW Induction Programme Final Internal Audit Peport (Reasonable Assurance)

ARAC_3.2b_PTHB 2324-04 HSCW Final Report.pdf (17 pages)

3.2.3. Health and Safety Arrangements Final Internal Audit Report (Reasonable Assurance)

ARAC_3.2c_PTHB 2324_23 Health and Safety Arrangements Final Audit Report.pdf (21 pages)

3.2.4. Incident Management Final Internal Audit Report (Reasonable Assurance)

ARAC_3.2d_PTHB-2324-05 Incident Management Final Audit Report.pdf (20 pages)

3.2.5. Information Governance Final Internal Audit Report (Limited Assurance)

ARAC_3.2e_PTHB-2324-09 IG Final Internal Audit Report.pdf (20 pages)

3.3. Internal Audit Themes and Reflections

Attached *Head of Internal Audit*

ARAC_3.3_Internal Audit Themes and Reflections Cover.pdf (4 pages)
ARAC_3.3a_Internal Audit Themes and Reflections Presentation.pdf (12 pages)

3.4. Audit Recommendation Tracking

Attached *Director of Corporate Governance/Board Secretary*

ARAC_3.4_Audit Recommendations_Report_Nov 23.pdf (4 pages)
ARAC_3.4a_App 1 Internal Audit Recommendations that remain OUTSTANDING.pdf (4 pages)
ARAC_3.4b_App 2 Internal Audit Recommendations COMPLETED since the previous report.pdf (2 pages)
ARAC_3.4c_App 3 Internal Audit Recommendations NOT YET DUE for implementation.pdf (1 pages)
ARAC_3.4d_App 4 External Audit Recommendation that remain OUTSTANDING.pdf (1 pages)
ARAC_3.4e_App 5 External Audit Recommendations NOT YET DUE for implementation.pdf (1 pages)
ARAC_3.4f_App 6 External Audit Recommendations COMPLETED since the previous report.pdf (1 pages)

3.5. External Audit Progress Report 2023-24

Attached *Audit Wales*

ARAC_3.5_PTHB Audit Wales ARAC Update January 2024 PDF.pdf (12 pages)

3.6. Counter Fraud Update

Attached *Head of Local Counter Fraud*

ARAC_3.6_ Counter Fraud Update Report.pdf (3 pages)
ARAC_3.6a_ Counter Fraud Update Report.pdf (4 pages)
ARAC_3.6b_Counter Fraud Update Report Appendix 2- Counter Fraud Investigations Update.pdf (3 pages)

3.7. Register of Interests and Register of Gifts and Hospitality

Attached *Director of Corporate Governance/Board Secretary*

ARAC_3.07_DoI and Gifts and Hospitality_January 24.pdf (4 pages)
ARAC_3.07a_Appendix A CGP 003 Standards of Behaviour Policy Review June 2022.pdf (46 pages)
ARAC_3.07b_Appendix B Board Members Register of Declarations of Interest.pdf (3 pages)
ARAC_3.07c_Appendix C Register of Gifts and Hospitality.pdf (1 pages)

10:00 - 10:00
0 min

4. ITEMS FOR DISCUSSION

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Committee Work programme

Attached

ARAC_5.1_ARAC Work Programme Jan 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: 12 March 2024 at 10.00 Microsoft Teams

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 16 JANUARY 2024 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**		
10.00	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous meetings held 10 October 2023	Attached	Chair
	1.4	Committee Action Log	Attached	Chair
		2. ITEMS FOR APPROVAL/RATIFICATION/DECISION		
10.105 mins	2.1	Application of Single Tender Waiver – including re provision of Orthodontic Treatment	Attached	Director of Finance, Information and IT
3 ITEMS FOR ASSURANCE				
10.15	3.1	Internal Audit Progress Report 2023-24	Attached	Head of Internal Audit
20 mins	3.2	Internal Audit Reports: a. Business Continuity Planning Final Internal Audit Report (*Substantial Assurance*) b. Clinical Education-HSCW Induction Programme Final Internal Audit Report (*Reasonable Assurance)* c. Health and Safety Arrangements Final Internal Audit Report (*Reasonable Assurance)* d. Incident Management Final Internal Audit Report (*Reasonable Assurance)* e. Information governance Final Internal Audit Report (*Limited Assurance)*		Head of Internal Audit
10.35	3.3	Internal Audit Themes and Reflections	Attached	Head of Internal Audit

20-30 mins				
11.05 20 mins	3.4	Audit Recommendation Tracking	Attached	Director of Corporate Governance/Board Secretary
11.25 5 mins	3.5	External Audit Progress Report 2023-24	Attached	Audit Wales
11.30 15 mins	3.6	Counter Fraud Update	Attached	Head of Local Counter Fraud
11.45 10 mins	3.7	Register of Interests and Register of Gifts and Hospitality	Attached	Director of Corporate Governance/Board Secretary
4 ITEMS FOR DISCUSSION				
	There are no items for inclusion in this section			
5 OTHER MATTERS				
11.55	5.1	Committee Work Programme	Attached	Director of Corporate Governance/Board Secretary
	5.3	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
	5.4	Any Other Urgent Business	Oral	Chair
12.00	5.5	Date of the Next Meeting: • 12 March 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.

However, considering the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public

will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

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

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 10 OCTOBER 2023 VIA MICROSOFT TEAMS

Present:

Rhobert Lewis	Independent Member (Chair)
Chris Walsh	Independent Member – Local Authority
Simon Wright	Independent Member – University (Substitute Member)
Steve Elliot	Independent Financial Advisor

In Attendance:

Pete Hopgood	Director of Finance and IT and Interim Deputy Chief Executive
Debra Wood-Lawson	Director of Workforce and Organisational Development
Sarah Pritchard	Head of Financial Services
Hywel Pullen	Deputy Director of Finance
Helen Bushell	Director of Corporate Governance/Board Secretary
Amanda Legge	Post payment Verification Manager
Anne Beegan	Audit Wales - Audit Manager
Ian Virgil	Head of Internal Audit
Matthew Evans	Head of Local Counter Fraud

Observers

Kirsten Jones	Llais

Committee Support

Belinda Mills	Corporate Governance Officer

Apologies

Ronnie Alexander	Independent Member – General
Mark Taylor	Independent Member – Capital and Estates
Hayley Thomas	Chief Executive Officer
Carl Cooper	PTHB Chair
Alice King	External Audit
Bethan Hopkins	External Audit
Jayne Gibbon	Internal Audit

ARA/23/035	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting. The Chair welcomed Steve Elliot as the new Special Advisor (Finance) to the Committee. Steve has been appointed by the Health Board to provide additional support to both this Committee and to the Delivery and Performance Committee whilst a new IM (finance) is recruited. For clarity, the role of Special Advisor (Finance) is not an Independent Member role. Apologies for absence were noted and recorded as above and that the meeting was chaired by Independent Member Rhobert Lewis.
ARA/23/036	**DECLARATIONS OF INTEREST** No interests were declared in addition to those already declared in the published register.
ARA/23/037	**MINUTES OF THE MEETINGS HELD 21 JULY 2023** The minutes of the meetings held on 21 JULY 2023 were AGREED as a true and accurate record subject to the following amendment: Page 9/10 – Core Structured Assessment with a focus on digital – amend to: 'Core Structured Assessment with a *separate* focus on digital'*.* The following matter arising was raised. ARA/23/028: The Chair noted that the External Auditor was of the understanding that the Audit Wales Report on Orthopaedic Services in Wales did not include English providers, but this information would be checked. The Audit Wales representative confirmed that the report did not include information in relation to English providers.
ARA/23/038	**COMMITTEE ACTION LOG** The Committee received the Action Log and the following actions were discussed: • ARA/23/006 (Provision of Orthodontic Treatment STW): It was noted that a project plan for assurance would be brought forward to Committee following the commencement of the tender process for STW POW2223040 (Orthodontic Treatment). It was noted that the action is on track with a paper scheduled for next meeting. • ARA/23/028 (Audit Wales – Orthopaedic Services in Wales): It was noted that this has been transferred to the Delivery and Performance Committee.
ARA/23/039	**APPLICATION OF SINGLE TENDER WAIVER** The Head of Financial Services presented report noting there had been one

Single tender waiver application made between 1 August and 30 September 2023.

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2324001	TENDER	Citizens Advice Powys	Citizens Advice Advisor service, specialising in working with individuals open to NHS mental health services.	Sole Supplier	31.7.23	£99,080	2 years	Prospective	A1

The Committee RATIFIED the use of Single Tender Waiver in respect of this item during the period of 1 1 August and 30 September 2023.

ARA/23/040

INTERNAL AUDIT PROGRESS REPORT 2023-24

The Head of Internal Audit presented the report which provided 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.

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

- Since the last meeting of the Committee two audits had been finalised and report completed:
  - SLAs for In-Reach Staff (Reasonable Assurance)
  - Clinical Audit (Reasonable Assurance)
- There had been a total of 24 audit reviews included with the 2023/24 Internal Audit Plan. At the time of reporting, one had been finalised with a further two at the draft report stage and two audits were currently work in progress with a further 13 at the planning stage.
- The progress report also includes details of a proposed adjustment to the timing of the Additional Learning Needs legislation audit. It had been requested that the timing of this audit was changed from Q2 to Q4 due to reviews being undertaken within the service.

Independent Members sought assurance as follows:

How confident are you that the ten reports expected in January will be delivered. Is that typical or realistic for the cycle?

The Head of Internal Audit confirmed that in previous years it was usual for more audits to come in the second half of the year. Work was ongoing towards having those ten audits complete and finalised so they can be

	brought to the Committee. This was dependent on whether the Health Board are able to support the audit work. The plan will be monitored and updated as necessary. *It is noted in Appendix A that two of the draft reports have limited assurance rating. Are the results of these findings shared with management and is any action taken on these emerging findings prior to publication of the final report?* The Head of Internal Audit confirmed that the findings have been shared and currently at a discussion stage with management prior to the report being finalised. The Director of Finance, Information and IT confirmed that as soon as an audit is completed all recommendations are collated and areas for improvement are identified. The team start working on actions immediately without waiting for final publication of the report. *With one of the audits postponed to Q4 are other planned audits being brought forward to fill the gap?* The Head of Internal Audit advised that there were other audits that could possibly be brought forward to fill that gap. However, it was also noted that the audit team which undertake internal audit in Powys, also deliver audits to other organisations and it would be necessary to take the wider workflow into account. The Committee: • NOTED the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports. • APPROVED the proposed adjustment to the timing of the Additional Learning Needs Legislation audit from quarter 2 to quarter 4.
ARA/23/041	**INTERNAL AUDIT REPORTS:** The Head of Internal Audit presented the report which provided 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. a. SLAs for In-reach Medical Staff (Reasonable Assurance) The Head of Internal Audit presented the report which sought to provide assurance over actions taken to review and update SLAs (Service Level Agreements) arrangement for in-reach medical staff across all Health Board services. It was noted that: • The Health Board needs to ensure that performance against the SLAs is being effectively reviewed during the Contract Quality Performance and Review Meetings and that this is clearly evidenced; • The Health Board did not obtain evidence relating to Disclosure and

Barring Service (DBS) checks, accreditation, registration, validation, job planning and appraisals of clinicians for 2022/23;
- An SLA had not been signed with one provider and the SLA with a second provider was not signed until after the period it covered had ended;
- The frequency of review meetings with each provider should be reviewed to consider what is most appropriate. This should then be reflected in the SLAs; and
- The system in place to capture all the in-reach arrangements requires improvement so that a clear, accurate and unambiguous position can easily be shown at any time.

In relation to '5.1 performance and quality monitoring against SLAs', can assurance be provided that the actions outlined in 5.1 in the agreed management plan will work?
The Director of Finance, Information and IT explained that the intention of this action was to ensure that the Health Board only pays for what is delivered.
The Head of Internal Audit confirmed that this recommendation was to make sure the Health Board actively monitors activity and ensures that it is getting what is paying for.

How do the Health Board check that it is monitoring, is there an internal process?
The Director of Finance and IT explained that the approach is to track sessions delivered, reconcile them to the invoice amounts and only then make payments for sessions provided.

Why might it take two or three months to get that point of ensuring payment was only made for sessions provided?
The Director of Finance, Information and IT undertook to bring a response to this question back to the next meeting.
Action: The Director of Finance, Information and IT

In relation to the service level agreements for this year, can assurance be provided that those are now in place, including the two with the cross-border providers?
The Director of Finance, Information and IT noted in respect of cross-border SLAs he was not aware of any outstanding arrangements but would check and bring a response back to the next meeting.
Action: The Director of Finance, Information and IT

The Head of Internal Audit added that at the point of completing the audit the commissioning team had only relatively recently taken on some of the responsibilities around the SLA monitoring. Some of the areas that were highlighted were areas where it was necessary to put processes in place and ensure they were properly embedded. It would be expected that

	implementation of these processes would take a few weeks. b. Clinical Audit Final Internal Audit Report *(Reasonable Assurance)* The Head of Internal Audit presented the report which sought to provide a review on the adequacy of the systems and controls in place for the planning, delivery and reporting of Clinical Audit work. It was noted that the Health Board has an approved Annual Clinical Audit plan in place, there is appropriate guidance available to staff and there are experienced staff in place to plan, coordinate and undertake the clinical audits. Three medium priority areas were identified during this audit including: • In the 2022-23 Clinical Audit Programme only 66% of the planned audits were fully completed; • The reports submitted to the Patient Experience, Quality and Safety (PEQS) Committee need to be enhanced to reflect outcomes or feedback on the audits that have been completed; and • Ensuring completed clinical audit files can be accessed. *What is the connection between this Audit report and the Patient Experience, Quality and Safety Committee?* The Director of Corporate Governance explained that Patient Experience Quality Committee is required to seek assurance that there is an internal audit plan in place, and this was done at their first meeting of the year in April 2023. The Audit Risk and Assurance Committee receives all Internal Audit Reports and monitors the implementation of the action plan to address recommendations. The Committee noted that the Health Board should ensure that sufficient resources are available for clinical audits from within service areas, this was noted in the agreed management action whereby the plan would be shared with colleagues to ensure that prioritisation of audits is shared. In addition, the Committee requested that an additional action/activity be undertaken to ensure colleagues are clear about the importance of clinical audit. **Action: Director of Corporate Governance** The Committee: • NOTED the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports. • APPROVED the proposed adjustments to the timing of the Additional Learning Needs Legislation audit.
ARA/23/042	**EXTERNAL AUDIT PROGRESS REPORT 2023-24** The External Audit Manager presented the item which provided an update on the current and planned accounts and performance audit work at Powys Teaching Health Board. The planned areas of work were outlined as follows:

- Review of unscheduled care – Part 1 field work is complete, and the report is in draft. Part 2 is due to commence in September 2023;
- Primary Care follow-up review – this audit is slightly delayed and will be brought to January 2023 Audit Risk and Assurance Committee;
- Workforce Planning review will be out for clearance in October and will be brought to the January or March 2024 Audit Risk and Assurance Committee;
- Structured Assessment - the draft report was being prepared and will be discussed with the Interim Chief Executive, Director of Finance; Information and IT, Director of Corporate Governance and Chair. This will then be reported to the Committee and the Board in due course;
- The deep dive into Digital will be deferred and replaced with a review of financial efficiencies. Financial efficiencies were originally planned for local work. The team will revisit what local work will take place instead, and it may be that this digital is looked at under local work. This will be confirmed in the next External Audit report to Audit Risk and Assurance Committee.

Independent Members sought assurance by asking the following questions:

Is it correct that in relation to review of unscheduled care all information is being collected and the review is currently in the draft stage?
The External Audit Manager explained that the draft report which focused on Discharge Out of Hospital was Part One and will come to the January 2023 Audit Risk and Assurance Committee. Part Two will focus the 'front door', i.e., how people were getting access to services, such as GP out of hours, minor injury units, and how well the 111 service was working. Part One was a regional report for the Health Board and the County Council and it is proposed that the Part One Report is considered by the to the Regional Partnership Board (RPB).

The Local Report included an examination of the actions taken by Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow, how has this been established?
The External Audit Manager advised that the arrangements in place for discharge had been examined. The focus for RPB had been interviews with the Chair along with meetings with various statutory members of the RPB.

A lot of focus in the RPB relates to the Regional Integration Funds (RIF) designed to facilitate more effective discharge. The RIF will be examined to ascertain if it is delivering what is needed to be delivered. The other aspect to be examined in relation to the RPB is to what extent the statutory bodies themselves are sighted of what is happening within the RPB and ensuring this is enabling strategic direction. This will be reflected in the January 2023 Audit Report which will be shared with the RPB.

How long has the RPB been in existence?

	The Director of Corporate Governance advised RPBs were set up under the Social Services and Wellbeing (Wales) Act 2014. The Committee DISCUSSED and NOTED the Report.
ARA/23/043	**COUNTER FRAUD UPDATE** The Head of Local Counter Fraud presented the item which provided an update on the key areas of work undertaken by the Counter Fraud Specialists during 2023/24. There has been lack of resource this year due to long-term sickness. Alternative arrangements have been utilised during this period of absence. It was highlighted that focus has been on increasing counter fraud awareness work. There had been a focus on the National Fraud Initiatives with proactive exercises that are run on a yearly basis. There are three exercises running concurrently each lead by specialists from different Health Boards. It was noted that the Economic Crime and Corporate Transparency Bill is currently in final amendment stage. This will bring in a new offence of failure to prevent fraud and will be enforced from late 2024. The National Fraud Initiative (NFI) reports contain data matched from payroll and other public sector organisations which highlight employees that are dual working or working whilst claiming sick leave. It can also flag staff on payroll who work for organisations that contract with the Health Board where procurement rules apply, and declarations of interest need to be made. Other NFIs look for duplicate creditors to ensure there is no invoice fraud. It was noted that issues relating to overpayment of salaries have been identified across NHS Wales. PTHB is not disproportionately affected by this issue. The Director of Finance, Information and IT advised that there are procedures and protocols in place to prevent this, but human error may lead to this taking place and the extra controls are welcomed. The Committee noted the ongoing support that had been provided by the wider Counter Fraud team in the absence of a Local Counter Fraud Specialist. The Committee RECEIVED the report for discussion and took ASSURANCE that appropriate counter fraud systems are in place.

ARA/23/044	**LOSES AND SPECIAL PAYMENTS REPORT** The Head of Financial Services presented the item which provided the Interim Report of Losses and Special payments for the period 1 April 2023 to 31 August 2023. It was noted that these payments fell into four key areas: • Clinical negligence and personal injury There was one receipt from Welsh Risk Pool in respect of Clinical Negligence and Personal Injury cases over 25k during 1st April 203 to 31st August 2023. • Redress (Putting Things Right) There are currently 6 open redress cases at variable stages. • General Medical Practice Indemnity (GMPI) There are currently 4 open GMPI cases at variable stages of review/progression. There has been no reimbursement to date from Welsh Risk Pool during 2023/23 in respect of GMPI cases. • Other Special Payments The Committee RECEIVED the Interim Report on Losses and Special payments covering the period 1st April 2023 to 31st August 2023 taking ASSURANCE relevant systems are in place to report losses and special payments.
ARA/23/045	**POST PAYMENT VERIFICATION (PPV) UPDATE** The Post Payment Verification Manager presented the item which provided an overview of how practices have been performing over the current Post Payment. PPV claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP). Assurance is not provided in relation to General Dental Service (GDS). Independent Members sought assurance by asking the following questions: *Can clarity be given on what is going to replace Medicine Use Review (MUR) service which was stopped because of Covid-19?* The Post Payment Verification Manager explained that MUR was stopped in March 2020 following Covid-19 and then PPV was stood down. Health Boards then requested that the Quality and Safety scheme to be subject to PPV. A pilot was conducted with another Health Board which was successful, and in April 2023 the Quality and Safety Scheme went live with communication sent to all community pharmacy to look at the collaborative working scheme. However, another potential initiative is being considered which would match invoice claims against prescriptions. The move to Electronic Prescribing expected to go live in 2024 has link to this.

	The Committee RECEIVED and took ASSURANCE that appropriate systems are in place to implement and monitor the Post Payment Verification (PPV) cycle.
ARA/23/046	**RISK MANAGEMENT ARRANGEMENTS** The Director of Corporate Governance presented the item which provided an update on the risk management arrangements, outlining some key actions in the coming months including the proposed focus for Audit Risk and Assurance Committee. The current Risk Management Framework has been in place since November 2022 as well as the Board approved Risk Appetite Statement. There were currently 12 risks on the Corporate Risk Register, which are reported to the Executive Committee and the Board bi-monthly. They are also reported to each of the other Committees where there is a responsibility in relation to those risks in their terms of reference. Risk registers are in place across all Directorates which vary in terms of their approach and how they are monitored. Health Board Programmes of work also hold programme risk registers. One of the key actions for this year was to re-establish the Risk and Assurance Group (RAG) which has been done. This group plays a key role in looking across the organisation and making sure that there is clear understanding of some of the Directorate risks and emerging risks. The Integrated Performance Framework and the Integrated Quality Framework both play a key role in terms of identifying emerging and future risks. There has been an internal audit undertaken on the Risk and Assurance Framework approach, a reasonable assurance rating was confirmed. Two recommendations from the 2022 Structured Assessment done by Audit Wales drew out a number of actions relating to the Board Assurance Framework both internally and externally which are being addressed. A Board Development session in November will deliver Risk Appetite training and the Board will revisit the Risk Appetite Statement. The Health Board is revising its Corporate Risk Register which was delayed given the current financial environment. It was noted that within the Corporate Risk Register there will be enhanced level of assurance reporting in 2024/25. Independent Members sought assurance by asking the following questions: *When will the Board Assurance Framework for this be available?* The Director of Corporate Governance noted that it will be available March 2024.

	The Committee RECEIVED the update and took ASSURANCE that the Risk Management Arrangements were appropriate.
ARA/23/047	**WELSH HEALTH CIRCULAR TRACKING** The Director of Corporate Governance presented the item which provided the Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHCs) and Ministerial Directions. It was highlighted that the report not only outlines the areas with no progress, partial or complete progress, but rather highlights those that are overdue as of September 2023. The appendices include additional detail including the Executive response. There remain a number of actions outstanding and the role for this Committee is to take assurance that there is a system in place to capture, monitor and report on progress against WHCs. *How many Welsh Health Circulars are received in a year?* The Director of Corporate Governance confirmed that quite a significant number of Welsh Health Circular are issued, this can be one or two a week. The Committee DISCUSSED the current position, taking assurance that the Health Board has a system in place to receive, manage and report against Welsh Health Circulars.
ARA/23/048	**REGISTER OF GIFTS AND HOSPITALITY** The Director of Corporate Governance presented the item which provided the latest position for the Register of Gifts and Hospitality for Board members and employees as of September 2023. It was noted that the Standards of Behaviour Policy enables the Board to ensure that its employees and Independent Members of the Board practice the highest standards of conduct and behaviour. The Committee was reminded that all items received above the value of £25 need to be declared and that communication would be shared with the organisation to remind colleagues of the Standards of Behaviour Policy. *How long has it been £25?* The Director of Corporate Governance stated that it has been quite consistent across the NHS for a long period of time, but it was a good point to be reviewed at the next policy review point. The Committee RECEIVED the contents of Register of Gifts and Hospitality for PTHB Board of September 2023 and took ASSURANCE that the organisation has appropriate processes to support the collection, management and reporting of declarations of gifts, in line with the Standards of Behaviour Policy.

ARA/23/049	**COMMITTEE WORK PROGRAMME** The Director of Governance highlighted the items noted for discussion at the January meeting would be included in the Work Programme. The Director of Workforce and OD presented the report and highlighted that the Health Board received the New Speaking up Safely Framework from Welsh Government via a Welsh Health Circular in September 2023. The timing had been brought forward because of the Letby case and it places an expectation on all staff and Board Members. It also requires Health Boards and other organisations to undertake a self-assessment and to put a development plan in place for any gaps that are identified. The self-assessment will be submitted to Welsh Government on the 30 October 2023 and will be brought back to Audit Committee. It was highlighted that there was a joint committee with Patient Experience, Quality and Safety and Workforce and Culture to look at the interrelationship between staff experience and patient experience. That meeting is scheduled for the 24 October 2023 and the draft Speaking up Safely Framework self-assessment will be sent to the Committee. The Committee RECEIVED and NOTED the Committee Work Programme.
ARA/23/050	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no matters to be brought to the attention of the Board and other Committees.
ARA/23/051	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/23/052	**DATE OF NEXT MEETING** 16 January 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:** A verbal update will be given to the meeting.	Jan-24		
10-Oct-23	ARA/23/041b	Director of Finance and IT	Internal Audit Reports	DFIT to provide assurance that all SLAs for 2023/24 are in place to the next meeting	**16.01.24 update**: A verbal update will be given to the meeting.	Jan-24		
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 16 JANUARY 2024)								
16-May-23	ARA/23/006	Director of Finance and IT	Provision of Orthodontic Treatment STW	A project plan for assurance would be brought forward to Committee following the commencement of the tender process for STW POW2223040 (Orthodontic Treatment)	**28.09.23 update**:On track paper scheduled for 16 January 2024 meeting.	16-Jan-24		Completed
10-Oct-23	ARA/23/041c	Director Corporate Governance	Internal Audit Reports	The Health Board to ensure sufficient resources available for clinical audits from within service areas and additional activity be undertaken to ensure colleagues are clear about the importance of clinical audit	**16.01.24 update:** Feedback provided to the Medical Director, 2024/25 plan currently being developed and the important message will be reinforced in the development of the plan and throughout the year	Jan-24		Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 16 January 2024**
Subject:	**SINGLE TENDER WAIVERS**
Approved and presented by:	Deputy CEO/Director of Finance, Information and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:

To seek the Audit, Risk and Assurance Committee's RATIFICATION of Single Tender Waiver requests made between 1st October 2023 and 31st December 2023.

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee:

- **RATIFIES** the use of Single Tender Waiver in respect of one item during the period of 1 October 2023 and 31 December 2023.

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 October 2023 meeting which covered the period from 1 July 2023 and 30 September 2023.

A summary of the use of Single Tender Action from 1 October 2023 and 31 December 2023 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2324002	TENDER	Clearhealth Ltd	Occupational Health Physician Services (Extension to STW POW2223036)	No NHS Provision available and clinical need	09/10/2023	£15,625	7 Months	Prospective	A1

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

Linked to Single Tender Waiver activity is Committee Action Point **ARA/23/006:** A project plan for assurance would be brought forward to Committee following the commencement of the tender process for STW POW2223040… (Orthodontic Treatment). An update note in response to this is included at **Appendix A2.**

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

NEXT STEPS:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.2

Audit, Risk and Assurance Committee	**Date of Meeting: 16th January 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.

RECOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Receive** the Internal Audit Progress Report, including the findings and conclusions from the finalised audit reports.
- **Approve** the proposed adjustments to the 2023/24 plan, namely to remove the following audits from the plan:
  - Efficiency Framework/Value Board
  - Staff recruitment and retention
  - Partnership Governance Framework.

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 October 23 meeting of the Committee:

- Business Continuity Planning (Substantial Assurance)
- Clinical Education - HCSW Induction Programme (Reasonable Assurance)
- Health & Safety Arrangements (Reasonable Assurance)
- Incident Management (Reasonable Assurance)
- Information Governance (Limited Assurance)

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

The progress report also includes details of proposed adjustments 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
January 2024

NWSSP Audit and Assurance Services

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

1. Introduction

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

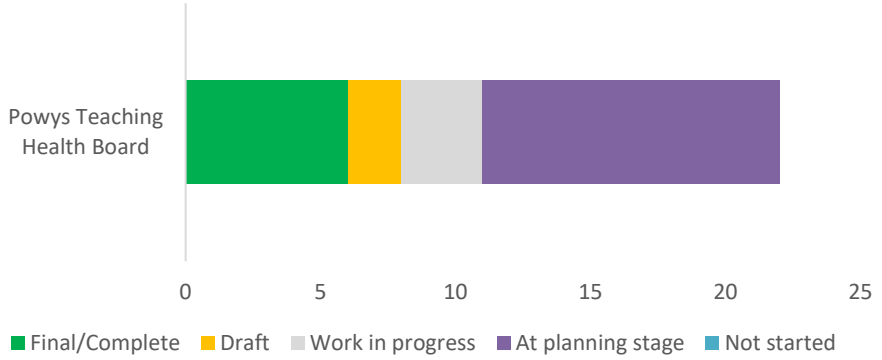
Five assignments from the 2023/24 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance rating.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Business Continuity Planning	Substantial	
Clinical Education - HCSW Induction Programme	Reasonable	
Health & Safety Arrangements		
Incident Management		
Information Governance	Limited	

3. Delivery of the 2023/24 Internal Audit Plan

There are a total of 22 reviews included within the 2023/24 Internal Audit Plan (including the changes detailed under section 4 below), and overall progress is summarised below.



The graph above illustrates that six audits have been finalised so far this year, with a further two at the draft report stage.

In addition, there are three audits that are currently work in progress with the remaining eleven 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.

4. Changes to the 2023/24 Plan

- **Efficiency Framework / Value Board**

  The Director of Corporate Governance proposed that this audit be removed from the plan due to Audit Wales focus on financial savings as part of their Structured Assessment. This has been agreed with the Executive Director of Finance, Information and IT.

- **Staff Recruitment & Retention**

  Proposed that this audit be removed from the plan due to focus on reducing staff costs as part of current savings plans. This has been agreed with the Executive Director of Workforce & OD.

  To be replaced by an audit of Decarbonisation

- **Partnership Governance Framework**

  The Director of Corporate Governance proposed that this audit should be deferred from the 23/24 plan and considered as part of the planning for 24/25 as the development of the Framework has not progressed as planned.

  This has been agreed with the Interim Director of Performance & Commissioning.

5. Development of the 2024/25 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors, Chief Executive, Chairman and key Independent Members during January to discuss potential areas for inclusion within the 2024/25 Internal Audit Plan.

An initial draft of the plan will then be submitted to a meeting of the Executive Team during February for review.

The updated plan will then be presented to the Audit, Risk and Assurance Committee for formal approval at the March 2024 meeting.

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
IT Infrastructure and Asset Management Follow-up	Follow-up of 22/23 Limited Assurance report.	11	Deputy CEO/Finance Information & IT Services	3		Draft	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*		*Draft*	*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		Work in Progress		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		March
Primary Care Dental Services	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		Work in Progress		March
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		Planning, draft brief issued		March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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	~~2~~	4	Planning, final Brief issued		March
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		Planning, final brief issued		March
Cyber Security Follow-up	Follow-up of 22/23 Limited Assurance report.	12	Deputy CEO/Finance Information & IT Services	4		Planning, final brief issued		March
Welsh Language Standards Follow-up	Follow-up of 22/23 Limited Assurance report.	16	Workforce & OD	4		Planning, final brief issued		March
Vaccination Programmes	Review the development of structures and plans for the on-going delivery of vaccination programmes.	21	Public Health	4		Planning, draft brief issued		March
Frailty / 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		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		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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		May
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		Planning, final brief issued		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. To be 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. To be 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. To be approved by January 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

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
Total assignments reported (to at least draft report stage) against plan to date for 2023/24	A	82% 9 from 11	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	89% 8 from 9	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	86% 6 from 7	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 7 from 7	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

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Business Continuity Planning
Final Internal Audit Report

December 2023

Powys Teaching Health Board

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

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

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Review reference:	PTHB-2223-22	
Report status:	Final	
Fieldwork commencement:	22 November 2023	
Fieldwork completion:	30 November 2023	
Draft report issued:	08 December 2023	
Management response received:	21 December 2023	
Final report issued:	22 December 2023	
Auditors:	Ian Virgill	Head of Internal Audit
	John Cundy	Principal Internal Auditor
Executive sign-off:	Mezz Bowley	Executive Director of Public Health
Distribution:	Donna Bale	Civil Contingencies 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.

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

The overall objective of this audit was to establish if the Health Board has appropriate arrangements in place to ensure effective business continuity at a corporate level. In addition, to provide assurance around the development of corporate level plans and that effective communication, training and testing of plans is undertaken.

Overview

We have issued substantial assurance on this area and have no significant issues or matters to report.

We have raised one low priority matter on document review, within the body of the report.

However, we should note that this review was limited to the corporate Business Continuity Planning (BCP) level. The Health Board should ensure that the BCP standards achieved are consistently replicated as the BCP plans progress through the service and operational levels of the organisation.

Report Opinion

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure	 2018/19

Assurance summary[1]

Objectives		Assurance
1	BCMS	Substantial
2	Staff Awareness	Substantial
3	Command and Control	Substantial
4	Lessons Learned	Substantial

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

1. Introduction

1.1 This audit review of Business Continuity Planning has been completed in line with the 2023/24 internal audit plan for Powys Teaching Health Board (the 'Health Board'). Business Continuity Planning is the process whereby an organisation takes steps to ensure it can maintain its services if/when an emergency has occurred.

The Civil Contingencies Act 2004 defines an emergency as 'an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK'. Emergencies are split into two distinct but overlapping concepts:

- major incidents: emergencies outside of the Health Board's day-to-day capabilities, including (but not limited to) severe weather, major transport incident, infectious disease outbreak or terrorist attack; and
- business continuity incidents: situations in which the Health Board's ability to provide core ('business critical') services is seriously compromised, resulting in potential significant disruption to services and risks to patient safety.

NHS organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential services will be maintained, and normal services restored as soon as possible.

As a Category 1 responder with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response.

1.2 The associated risks for the audit are:

- Lack of a defined approach to business continuity planning;
- No real accountability within the planning process;
- Inability to maintain services during a business continuity incident leading to widespread disruption for the Health Board which could jeopardise patient safety; and
- No oversight of whether the business continuity plans cover all different aspects of the organisation.

1.3 Limitation to scope:

- IT technical resilience and disaster recovery is excluded from the scope of this review; and
- Business Continuity planning within individual service directorates/divisions is also excluded from the current scope.

2. Detailed Audit Findings

Objective 1: There are appropriate business continuity management systems and supporting processes in place at a corporate level.

2.1 The Health Board has a Business Continuity Management System in place with a Business Continuity Management Policy CGP 001 (BCMP) and a Corporate Business Continuity Plan Ver4.1(BCP). Both documents are currently dated and have a document history showing regular review and update.

2.2 These documents are supported by a series of sub-plans to deal with specific threats. E.G. The PTHB Major Incident and Emergency Response Plan; The PTHB Severe Weather Plan; The PTHB Pandemic framework. All of the sub-plans are consistent in format and content with defined actions covering enactment, communication, operation, and stand-down.

2.3 The BCMP and Corporate BCP clearly define staff responsibilities in the event of a business continuity situation. There are clearly defined command structures, roles and responsibilities for all staff involved in all roles in the business continuity management process.

2.4 They also define the levels of incident response, levels one and two require a local management response and may not necessitate full BCP activation, levels 3 and 4 are more significant, and will require full BCP activation and enhanced cooperation with the other category 1 responders.

2.5 The Health Board, along with the other category 1 responders in the area e.g. Powys County Council and Dyfed Powys Police, are part of the Dyfed Powys Local Resilience Forum. The Health Board and Powys County Council use the same Business Continuity Toolkit which helps ensure consistent documentation for the planned response across the area.

2.6 The toolkit consists of three document templates completion of which is essential for appropriate continuity management:

- Business Impact Analysis (BIA) which is used to assess all particular workstreams and deliverables and consider what could happen to them in the event of a risk materialising, resulting in an emergency situation arising.
- Critical Activity Identification (CAI), which prompts assessing those workstreams and deliverables and considering their criticality in terms of the impact of the loss of the activity; i.e. how long can the loss be tolerated. Critical means it needs to be restored within an hour; Core within a day; Reduced is within 5 working days; Suspended is progressively restored after 5 working days.
- A service level Business Continuity Plan (BCP) which will define the actions taken to maintain the workstreams and deliverables within their level of criticality until the emergency is declared over and the BCP is 'stood down'.

2.7 The toolkit BIA has enabled all services provided by the Health Board to be rated for criticality, with a complete list produced at Annex B of the Corporate BCP. We have reviewed a selection of the Service level BIA and are satisfied the plan list is

complete and accurately compiled. Although service level BCP are outside of the scope of this audit we note that the service areas have all produced a BIA for their services.

2.8 There are two BCP relevant risks on the corporate risk register which are managed according to the Health Board Risk Management Policy. Additionally, as several of the risks relating to BCP situations are national the corporate BCP links to the National Risk Register (UK) which lists risks and response guidance to known threats, e.g. a national power outage, or severe weather, flooding etc.

2.9 For BCP emergencies the Dyfed Powys Local Resilience Forum has a community risk register which takes some of the national risks which are more likely to occur in the area, flooding, extreme weather etc. and plans for a combined response from the forum participants.

Conclusion:

2.10 We have found the corporate business continuity system, its policy, plan and supporting documents to be complete, consistent and comprehensive. We have provided Substantial assurance for this objective.

Objective 2: Relevant staff are aware of corporate business continuity plans and the actions required during an incident.

2.11 The Health Board maintains a training plan which contains a matrix listing all the designated roles within the business continuity process and the training requirements for each of them, including if it must be repeated periodically. We note the plan is currently out of date (2019) and that work is ongoing at present to update the document. (Matter Arising 1)

2.12 The training for the Gold and Silver on-call officers has recently been refreshed and updated. There is a list of the on-call officers within the Health Board which includes the date of their BCP training. We note that a large proportion of them have had the training within the last two years and that the updated training is readily available from the Civil contingencies Manager.

2.13 All of the BCP roles require specific actions to be followed in a coordinated manner for the BCP to succeed. Every defined role in the plans has a defined action card included in the plan which is updated as part of the plan review process.

2.14 The Health Board has a civil contingencies website with a link to the new NHS Wales e-learning package entitled 'Introduction to Emergencies' which is available to all through ESR. We note that all staff are encouraged to complete the thirty-minute course, though it is not mandatory.

2.15 We note there has been a program of internal and external civil contingencies training events throughout the year and there are regular reminders about BCP and civil contingency measures in the staff bulletins and newsletters that are periodically issued.

Conclusion:

2.16 Although there are some documents that are well past their review date, we are satisfied that the training and communication of the requirements of the business continuity processes have been well promoted throughout the Health Board. We have provided substantial assurance for this objective.

Objective 3: Appropriate command structure and communications are in place in the event of a continuity event occurring.

2.17 There is a single command and control structure defined in all of the BCP. There is a defined PTHB Business Continuity Incident Escalation and Response Process which specifies the actions to be taken depending on the level of response initially assessed.

2.18 Level 1 or 2 incident response use localised business continuity arrangements. Levels 3 or 4 require notification of the Gold on-call commander and notification of executive leads. All lower levels of incident have appropriate escalation process should the situation demand it. The BCP contains clear descriptions of the scale of the impact which is used to assess the incident level and the response required.

2.19 The response process requires specific actions from the specific people and teams as per the plan. These actions are all defined in the Action Cards included in the plan. The plan also has templates for meeting agenda, and call and logging templates which can further promote the consistency of the planned response.

2.20 The Health Board has a designated location which is set up to act as an emergency control room with hard copies of the plans and cards if required. The location itself is identified as a critical service by the Health Boards Community Services Group with a recovery time objective of one hour if it is actually affected by the incident, though the plans make its activation and use the decision of the incidents on-call manager.

2.21 The Health Board has a 'PTHB Emergency Contacts Directory' which contains contact details, official and personal for all the key contacts necessary to support the activation of the PTHB Emergency Response Team. There are contact details for key locations e.g. hospitals in the directory and external emergency contacts e.g. Dyfed Powys police, WAST etc.

Conclusion:

2.22 The PTHB BCP command and control structures are well defined and documented, have been tested and are subject to continuous review. We have provided substantial assurance for this objective.

Objective 4: The Health Board has processes in place for testing plans and incorporating lessons learned from events such as the Covid-19 pandemic response.

2.23 There is a record of all civic contingencies incidents that have occurred in the year with details of the response provided. These are summarised and reported to the Board in the Civil Contingencies Annual Report.

2.24 The report confirms that lessons learned have been recorded internally and used to refine the Health Boards BCP, which has also incorporated recommendations

from the NHS Wales Lessons Learnt register as considered appropriate. The NHS Wales Lessons Learnt Register provides a single resource in which all health-related lessons that have been identified following regional and national debriefs and Public Inquiries are captured.

2.25 There is an ongoing series of tests and exercise of the BCP, both internal, and wider involving the Dyfed Powys Local Resilience Forum, e.g. exercise Mighty Oak which was based on a national power outage.

2.26 The Health Board demonstrates a proactive and co-ordinated approach to warning and informing, sharing best practice, and encouraging a joint approach to emergency preparedness, by working in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements, including:-

- Dyfed Powys Local Resilience Forum and relevant subgroups;
- All Wales NHS Emergency Planning Advisory Group and relevant subgroups;
- Royal Welsh Show Emergency Planning Committee;
- Powys Safety Advisory Groups;
- Builth Wells Safety Event Group; and
- Local and Regional CONTEST Board.

Conclusion:

2.27 The Health Board BCP has an appropriate BCP testing, and lessons learnt process in place. We have provided substantial assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Document Review (Operation)			**Impact**
During the audit we noted that several of the BCP documents reviewed are overdue for review e.g. The Pandemic Flu Framework which was due for review in 2016. The civil contingencies training and exercise plan which was due for review 2020.			Potential risk of: • Incorrect information on out-of-date documents.
Recommendations			**Priority**
1	Documents past due for review should be brought up to date as soon as possible. Key documents should be recorded on a schedule so that they can always be kept 'current'.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	The Civil Contingencies Training and Exercise Plan has been reviewed and has been presented to the Executive Committee for approval on 13/12/23.	Complete	Civil Contingencies Manager
	The revised Pandemic Framework is due to be presented to the Executive committee for approval in mid-February 2024.	29/02/24	Civil Contingencies Manager

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Clinical Education – HCSW Induction Programme

Final Internal Audit Report

November 2023

Powys Teaching Health Board

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

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

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Auditors:	Ian Virgil, Head of Internal Audit Jayne Gibbon, Audit Manager Sharon Edwards, Principal Auditor
Executive sign-off:	Debra Wood-Lawson, Executive Director of Workforce & Organisational Development
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Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

The overall objective of the audit was 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.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Development of a procedure for the HCSW Induction Programme.
- Reviewing the information currently recorded within the induction tracker.
- Reviewing HCSW's qualifications to avoid scheduling unnecessary training sessions.
- Understanding reasons for delay in completing portfolios or staff withdrawing from the programme.
- Implementation of a reporting structure for the HCSW Induction Programme within the Health Board.

Other recommendations are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Adequate Resource	Reasonable
3	Monitoring and Reporting	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Governance arrangements	1	Design	Medium
2	Induction Tracker	1	Operation	Medium
3	New Starters	2	Design	Medium
4	HCSW Portfolios	2	Operation	Medium
5	Monitoring and Reporting	3	Design	High

1. Introduction

1.1 Our review of the Clinical Education – HCSW Induction Programme has been completed in line with the 2023/24 Internal Audit Plan for the Powys Teaching Health Board (the 'Health Board').

1.2 The purpose of the All Wales 'Developing Excellence in Healthcare – An NHS Wales Skills and Career Framework for Healthcare Support Workers supporting Nursing and the Allied Health Professionals' (the 'Framework') is to provide a governance mechanism to inform the skills and career development of the Healthcare Support Worker (HCSW) workforce in NHS Wales.

1.3 This resource is relevant to all HCSWs in Nursing, Midwifery and Allied Health Professional (AHP) roles within NHS Wales Health Boards and Trusts. It will support current and future role development by standardising the scope of these roles, and through the development of Learning Pathways it will provide the underpinning knowledge and skills to practice safely.

1.4 The Framework will support the HCSW careers and increase the professionalisation of this core workforce, building on the high-quality services already delivered to individuals by the workforce.

1.5 As part of the Framework, on appointment, every HCSW in Wales should complete a robust induction programme to include the UK Core Skills Training Framework (required by all staff working in NHS Wales) and an Induction Programme. This will provide HCSWs with the foundation knowledge to practice in a safe, compassionate, and dignified manner in their area of work.

1.6 The Executive lead for the review is the Executive Director of Workforce and Organisation Development.

2. Detailed Audit Findings

Objective 1: There are effective governance arrangements in place to oversee the implementation of the Induction Programme.

2.1 The Health Care Support Worker (HCSW) programme is externally accredited, which ensures external quality assurance is in place.

2.2 Over recent years the HCSW training has been brought in-house, which enables the Health Board to support the growth of the workforce across Powys by supporting staff to complete the Induction Certificate.

2.3 Guidance and information regarding the HCSW Induction Programme can be found on the intranet within the Clinical Education Section with links to various information, including booking onto the course.

2.4 There is an induction tracker in place which records details of all eligible staff that are required to attend the programme and provides an update on what stage they are at. However, the person responsible for maintaining the Induction Tracker has left the Clinical Education team and there is no formal documented process in place detailing what information is required for the tracker. **(Matter Arising 1)**

2.5 The Clinical Education team lacks a robust process for identifying staff who are eligible to undertake the Induction Programme. We were provided with a copy of the Standard Operating Procedure (SOP) which is in place for identifying eligible staff appointed through the Temporary Staffing Unit (TSU) but there is no reference to staff that are appointed to substantive posts. **(Matter Arising 1)**

2.6 Although the Induction Tracker records the number of attendees, the figures that have been noted within the spreadsheet, do not all correspond with the information in individual 'tabs' which could lead to a lack of confidence in the figures that have been reported. **(Matter Arising 2)**

Conclusion:

2.7 The current arrangements for overseeing the Induction Programme require enhancing. We have provided **Reasonable Assurance** for this objective.

Objective 2: There are adequate resources in place to facilitate the delivery of the HCSW induction programme ensuring compliance with the requirements of the Framework.

2.8 There are currently two Clinical Skills Practice facilitators / educators who deliver the training, which is facilitated by holding online classroom training via teams for two days with face-to-face training provided for the third day.

2.9 Once a HCSW has enrolled on the Induction Programme the course material will be issued from the Clinical Education team.

2.10 Once the HCSW has concluded the induction program and they have submitted their portfolio, this will be assessed and Internally Quality Assessed (IQA). Once the portfolio is assessed and IQA'd the staff member will be registered with Agored where their certificate can be claimed. An email is sent out to notify the TSU / Recruitment Departments that the HCSW has completed and passed the induction programme and is ready to work.

2.11 As HCSW qualifications are not routinely noted for staff when they are recruited to the Health Board, additional training sessions have been added to accommodate them only to discover they have already completed Level 2 training, which supersedes the induction training. Consequently, unnecessary sessions are held, and time is wasted. **(Matter Arising 3)**

2.12 Portfolios should be completed within 12 weeks but from our review of the information recorded on the Induction Tracker, it was established that there are a number of staff who have not met that deadline and likewise, there are a large number of HCSW's who withdraw from the course. The reasons for the delays or withdrawals are not noted. **(Matter Arising 4)**

Conclusion:

2.13 The tracker has recorded some fundamental information but should be enhanced to provide more purposeful information that can be used to inform future reporting and also scheduling of training sessions. We have provided **Reasonable Assurance** for this objective.

Objective 3: The Health Board has arrangements in place for monitoring and reporting on implementation of the Framework and delivery of the HCSW Induction Programme.

2.14 All Wales Operational Meetings have been organised and chaired by HEIW. These meetings are held every 8 weeks where the Clinical Educators across Wales can share knowledge and experience of issues they have faced or good practice they have experienced.

2.15 The Induction Tracker is in place, and although the information is used to report on an annual basis to HEIW, we were unable to verify whether the information collected by the team was reported anywhere within the Clinical Education Department.

2.16 From our fieldwork we have been unable to identify a formal process for reporting and monitoring on the HCSW Programme within the Workforce and Organisational Development Department and therefore the Health Board. **(Matter Arising 5)**

Conclusion:

2.17 A more robust internal reporting and monitoring process needs to be implemented to facilitate the Induction Programme. We have provided **Limited Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Governance Arrangements (Design)	**Impact**
The Clinical Education team does not have a robust process for identifying staff that are eligible to undertake the Induction Programme, such as through completing an application on the intranet / Temporary Staffing Unit or the Recruitment Department. Information is provided from the Temporary Staffing Unit for new bank starters but there is little communication or reporting provided. There is a Standard Operating Procedure in place, but this does not identify the Induction Programme pathway and does not set out the clear roles and the responsibilities for the Clinical Educators / Admin or Recruiting Managers. As a result of this, it may mean that the Health Board is not capturing or reporting all the Health Care Support Workers including all substantive staff who require the necessary training. The Induction tracker has been used previously to log all staff who are enrolling onto the HCSW programme; However, the administrator who was managing this process has left the role. The team does not currently have comprehensive desk top procedures describing all aspects of the process and without these instructions, it may be difficult for someone new to pick up the process.	Potential risk of: • Failure to comply with All Wales guidance. • Reduced quality of care if staff are not adequately trained.

Recommendations		**Priority**
1.1	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.	**Medium**
1.2	Management should also consider including within the SOP the process for updating the Induction Tracker to cover the information required and outlining Department responsibilities.	

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The clinical Education team will revise the SOP to identify the roles and responsibilities of Recruiting Managers and TSU.	By end Dec 2023	Head of Clinical Education

1.2	To include the process for updating the tracker as part of 1.1 revised SOP.	By end Dec 2023	Head of Clinical Education

Matter Arising 2: Induction tracker (Operation)	Impact
The Clinical Education Department maintains an Induction Tracker to record the activity of the HCSW Induction Programme. The Induction Tracker records the number of attendees, and these figures should total the number of people who have completed the programme and the number that have withdrawn as at present, not all of the figures on the tracker correspond which could lead to a lack of confidence in the figures that have been quoted / reported. When reviewing the Tracker with the Head of Clinical Education the following observations were made: • the number of attendees on the summary page does not correspond with the number of people on the induction tracker tab. • The information is not broken down by year, which would make it easier to review. • Some of the information held within the tracker may be unnecessary i.e. address, phone number etc. • There were blanks within some of the columns i.e. whether staff have passed or been referred / there are no notes or comments to explain any delays / reasons why there are blanks in the columns for informing the Temporary Staffing Unit (TSU) • there are hyperlinks to blank letters on every line of the spreadsheet which are used to notify the TSU, but it may be more appropriate to hyperlink the actual letter sent so there is an appropriate audit trail.	Potential risk of: • Inaccurate information being reported

Recommendations		Priority
2	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.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2	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.	By end January 2024	Head of Clinical Education in conjunction with the Clinical Ed administrator

Matter Arising 3: New Starters (Design)			**Impact**
There are instances where an employee's qualifications have not been noted and they have been enrolled in the Induction Programme despite the fact that they have already completed Level 2 training. As a result, this leads to the Clinical Educators scheduling unnecessary sessions that then need to be cancelled. At present the team are unable to provide assurance that all substantive HCSW's in post have received the necessary training as they can't substantiate: • How many HCSW are currently in post. • How many have received the training. • How many have the level two qualification.			Potential risk of: • Failure to comply with All Wales guidance.
Recommendations			**Priority**
3	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**	**Responsible Officer**
3	In support of 1.1 above 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.	By end of March 2024	Head of Clinical Education

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Matter Arising 4: HCSW Portfolios (Operation)	**Impact**
Portfolios should be completed within 12 weeks but from reviewing the Induction tracker it was clear to see that there are a number of staff who did not complete the portfolio within that timescale. The Induction Tracker currently does not identify: • how long the portfolio took to be completed; although it was evident from reviewing the date that staff registered and the date the portfolios were completed that a large number took over 3 months to complete. • Any reasons why the portfolio took so long i.e. sickness, only works one day a week etc as this would help establish if there was an issue with completing the workbook portfolio or identifying any patterns. The tracker could also be enhanced as although a record is kept of all staff members who have withdrawn from the course, the reasons for this have not been identified. When speaking with one ward manager, it was noted that staff who undertook a shadow shift as part of the Induction Programme found it a daunting experience as they weren't used to working within a ward environment.	Potential risk of: • Reduced quality of patient care if staff are not adequately trained

Recommendations		**Priority**
4.1	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.	**Medium**
4.2	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.	

Agreed Management Action		Target Date	Responsible Officer
4.1	An SOP will be developed to manage reminders and requests for completed portfolios. This link also link to 2.0 above.	By End of January 2024	Head of Clinical Education in conjunction with the Clinical Ed administrator
4.2	The Head of Clinical Education will seek advice at the next HCSW all Wales meeting.	By end of November 2023	Head of Clinical Education

Matter Arising 5: Monitoring and Reporting (Design)	**Impact**
The Induction Programme has been brought "in house" and is run by the Clinical Education department. The program reports into an All-Wales Operational Meeting, held and chaired by HEIW, with all Clinical Educators throughout NHS Wales invited to attend. The Head of Clinical Education is unaware of what information is used to produce data for these meetings. Due to work demands, the Clinical Educators within Powys, are not always able to attend these meetings in person but catch up via the recordings of the meetings on teams. Within the Workforce & Organisational Development Department / Health Board we have received limited evidence of any formal monitoring or reporting arrangements regarding the HCSW Induction Programme. The Clinical Education Department needs to strengthen the reporting and monitoring arrangements of the Health Care Support Workers Induction Programme as at present the team do not: • receive feedback from the HEIW Operational Meetings. • Review the Induction Tracker • Hold meetings where discussions are held on attendance figures. • Identify issues such as withdrawals from the programme, or discussions on the time taken to complete the portfolio. • feedback provided from the end users. The team meeting should also be used to highlight any achievements within the programme.	Potential risk of: • Reduced quality of patient care if staff are not adequately trained

Recommendations		**Priority**
5	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.	**High**

Agreed Management Action		Target Date	Responsible Officer
5	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.	There are quarterly DWOD reports and this item will be included as appropriate. Commence Jan 2024 if not before.	Assistant Director of OD

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Health and Safety Arrangements
Final Internal Audit Report

December 2023

Powys Teaching Health Board

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

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Jayne Gibbon, Audit Manager Ian Virgill, Head of Internal Audit
Executive sign-off:	Clare Madsen, Executive Director of Therapies and Health Science
Distribution:	Jason Crowl, Assistant Director of Support Services - Health & Safety Lead Emily Groves, Business Support Manager – Health & Safety
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 this audit was to review and assess the adequacy of the processes in place within the Health Board to ensure compliance with Health & Safety legislation.

Overview

We have issued reasonable assurance for this audit.

The matters requiring management attention include:

- Improving the processes in place for the identification of health and safety training requirements to ensure that all staff receive appropriate training.
- Clarifying the Committee reporting structure for the Health & Safety Group.
- Formalising the monitoring and reporting arrangements for Health & Safety Training.

Other recommendations are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	The Health Board has health and safety policies in place which comply with the requirements of health and safety legislation. The policies are accessible to staff	Substantial
2	Training requirements and needs have been identified for staff. Training is undertaken and up to date	Limited
3	The health board has an appropriate structure to manage health and safety responsibilities and governance arrangements are in place for the regular monitoring and reporting of health and safety matters	Reasonable
4	Health & Safety risks are appropriately assessed and there is an up-to-date health and safety risk register in place	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Training	2	Operation	High
3	Health and Safety Reporting to Committees	3	Operation	Medium
4	Monitoring & Reporting of Training Compliance	3	Operation	Medium

1. Introduction

1.1 Our review of Health and Safety Arrangements was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The Health and Safety at Work Act (1974)[1] places a legal duty on organisations to have put in place suitable arrangements to manage health and safety and establish a policy as an integral part of the Health Board's culture, values, and performance standards. The successful delivery of the policy depends on an effective management system encompassing all employees and stakeholders of the Health Board. It is essential that the Health Board demonstrates compliance with the Act through robust governance arrangements.

1.3 The Executive lead for this review was the Executive Director of Therapies and Health Science.

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

- The Health Board does not have adequate health and safety arrangements in place;
- The Health Board does not comply with health and safety legislation resulting in potential harm, financial penalties and reputational damage; and
- The Health Board is unaware of issues concerning Health & Safety.

2. Detailed Audit Findings

Objective 1: The Health Board has health and safety policies in place which comply with the requirements of health and safety legislation. The policies are accessible to staff.

2.1 The Health Board has a Health and Safety (H&S) policy which was approved by the Executive Committee in March 2022 and with a review date of March 2025.

2.2 There are additional supporting policies and procedures (as detailed in the table below) listed as a part of Appendix 1 of the main Health Board's H&S policy.

Reference number	Policy title	Reference number	Policy title
PTHB HSP003	Manual Handling Policy	PTHB HSP012	The Control of Risks at Work to Young Persons Policy and Procedure
PTHB HSP004	Hand Arm Vibration	PTHB HSP013	Control of Substances Hazardous to Health (COSHH) Policy & Procedure
PTHB HSP005	Violence and Aggression Policy	PTHB HSP018	First Aid at Work Policy
PTHB HSP006	Lone Working Policy & Procedure	EWP 015	Reducing False Alarms Procedure & Guidance

[1] Health and Safety at Work etc. Act 1974 (legislation.gov.uk)

PTHB HSP007	Display Screen Equipment Policy (DSE)	EWP 016	Fire Risk Assessment Procedures and Guidance
PTHB HSP008	Management of Contractors	EWP 017	Arson Prevention Procedures
PTHB HSP010	New and Expectant Mothers Policy and Procedure	EWP 018	Emergency Evacuation of Disabled Persons
PTHB HSP011	Stress Management Policy (Wellbeing in the Workplace)	PTHB FTP 005	Security Protective Measures Policy

2.3 A review was undertaken of the policies/procedures to ensure they were up to date, adequately approved and uploaded on the intranet they are available to all staff. This review found that one policy was overdue for review, two recently approved policies and procedures were yet to be published on the intranet and some of the references for the supporting policies and procedures detailed within the Health Board's main H&S policy differed to the references of the actual documents uploaded on the Intranet. **(Matter Arising 1)**

2.4 There is a Health & Safety page on the Health Board's intranet that is available to all staff. Information published on the page includes:

- the H&S policies and procedures;
- key contacts email details and the areas they cover;
- Information on manual handling, violence & aggression, fire safety; and
- Health & safety training - Institution of Occupational Safety (IOSH) and Health and National Examination Board in Occupational Safety and Health (NEBOSH)

Conclusion:

2.5 The Board has a H&S policy in place which is supported by a number of additional policies and procedures which are available to all staff. A number of minor issues were identified concerning some of the policies. We have provided **Substantial Assurance** for this objective.

Objective 2: Training requirements and needs have been identified for staff. Training is undertaken and up to date.

2.6 All staff within the Health Board are required to complete the standard statutory and mandatory ESR training. A training matrix for statutory and mandatory training was agreed by the Executive team in 2020 and includes the following Health & Safety related modules; Manual Handling, Fire Safety, Violence and Aggression.

2.7 Appendix 4 of the Health & Safety policy identifies the Institute of Occupational Safety and Health (IOSH) training requirements relevant to the roles for different levels of staff employed within the Health Board. There are 3 main levels of training which will vary depending on the grade of the individual member of staff.

2.8 A paper was submitted to the H&S group in July 2023 which outlined the costs associated with the provision of health and safety training to comply with the legal

requirements and arrangements as detailed in the Health & Safety policy. Within the paper was specific details relating to the provision of IOSH training modules which would not only be costly but could be difficult to provide to every member of staff. **(Matter Arising 2)**

2.9 Competency Specific training is provided to staff that are required to use equipment such as hand drills, floor scrubbers and gardening tools. However, there is no database in place that identifies all staff that require such training, the type of equipment training was required for or when training was provided. **(Matter Arising 2)**

2.10 The Senior H&S officers provided IOSH working safely courses up to April 2023, for which they are required to obtain an appropriate professional qualification. As part of their roles, they are also required to attend a number of Health and safety related meetings. However, we noted that for these staff there is currently no training needs analysis in place to identify their training requirements. **(Matter Arising 2)**

2.11 We do note that a request to complete a local training needs analysis was circulated via email in October 2023 to Deputy and Assistant Directors of all Directorates within the Health Board. The H&S group wants to establish the training needs for H&S purposes which is usually delivered at the service level.

Conclusion:

2.12 Whilst Health & Safety training requirements are identified within the Health & Safety Policy, our audit highlights a number of issues concerning the identification of the training needs of staff as well as the delivery of this training. We have provided **Limited Assurance** for this objective.

Objective 3: The health board has an appropriate structure to manage health and safety responsibilities and governance arrangements are in place for the regular monitoring and reporting of health and safety matters.

2.13 The nominated executive lead assigned for health and safety is the Executive Director of Therapies & Health Science. The Health & Safety policy details the governance arrangements, although we acknowledge that, at the time of audit, there were interim arrangements in place concerning the chairing of the Health & Safety group and its subgroups (Fire group, Security group and Site Co-ordination forum).

2.14 There are two senior Health & Safety Officers that work with staff locally to:

- Provide training;
- Discuss concerns regarding health and safety;
- Attend Estates meetings; and
- Attend advisory & compliance meetings (fire safety and water safety)

2.15 We note that reports on health and safety were presented to the Executive Committee and the Delivery & Performance Committee meetings that took place

in February & August 2023. However, we have been unable to evidence that the 2022/23 annual H&S report was submitted to the March 2023 Board meeting.

2.16 The Health & Safety Group Terms of Reference (ToR) state that it reports to the Patient Experience, Quality and Safety Committee. However, the Health & safety policy notes that for communications issues regarding health & safety the group was accountable to the Delivery & Performance Committee, and for matters concerning audits and inspection the group was accountable to the Patient Experience, Quality & Safety Committee. As noted in paragraph 2.15 we were able to evidence updates submitted to the Delivery & Performance Committee but not to the Patient Experience, Quality & Safety Committee. **(Matter Arising 3)**

2.17 The H&S group has three sub-groups which report to it. These are:

- Fire Safety Group;
- Security Oversight Group; and
- Site Co-ordination Group.

2.18 The Health & Safety Group ToR are up to date although, as noted in paragraph 2.16 the reporting/accountability arrangements need to be reviewed and clarified. From our review of meetings that had taken place in 2023 we can confirm that all meetings were quorate.

2.19 The H&S group agenda includes an 'escalation of issues identified at its sub-groups' and 'to agree any issues to be escalated to the Executive team' section. We were able to evidence that updates were reported within the minutes as and when exceptions were noted from the fire safety group, security oversight group and site co-ordination forum.

2.20 The H&S team provides updates to the H&S group on health and safety staff related incidents. The format of the information includes statistics, analysis and trends.

2.21 The Health & Safety group does not formally review or monitor compliance with statutory and mandatory health and safety modules/courses or the IOSH training requirements. **(Matter Arising 4)**

2.22 There is a H&S Group Workplan in place for 2023/24 and a progress report was presented at the October 2023 H&S group meeting. The plan sets out the actions the group will take regarding Health & Safety focussing on arrangements for Assurance, Reporting and Learning, Training, Compliance and Inspection.

2.23 The H&S group receives a highlight report from each of the Health Board's Directorates. The new standardised highlight template report was used for the first time at the October 2023 meeting. This includes the following key themes:

- Escalation from local health and safety meetings;
- H&S Reported Incidents;
- RIDDOR reported cases;
- Shared learning;
- H&S risk Management;

- H&S Audits completed;
- H&S statutory & mandatory training compliance; and
- Actions for improvement.

2.24 For the October 2023 Health & Safety meeting all Directorate Highlight reports were submitted using the new template. From reviewing the reports, we identified issues relating to the information reported on statutory and mandatory training compliance, with differences in the contents of details provided and also the time periods that the information related to. **(Matter Arising 5)**

2.25 We reviewed the ToR for each of the three H&S sub-groups, along with a sample of the meetings for each sub-group to establish if they were quorate and held in accordance with the requirements of the ToR. This identified the following issues:

- The accountability details for the Fire Safety Group differed to those detailed in the main Health & Safety policy;
- The Security Oversight Group is not submitting a quarterly highlight report to the Health & Safety Group;
- The ToR for the Site Co-ordination Group are overdue for review and the frequency of meetings has not been in accordance with the ToR.

(Matter Arising 6)

2.26 At each meeting of the Site Coordination Group, the Site Representatives are expected to present highlight reports, that provide updates pertaining to their respective sites. These highlight reports are uploaded onto Teams. Included in the Group's meeting agenda is an item for the escalation to H&S as a standing agenda item.

Conclusion:

2.27 The Health Board has a number of groups in place to oversee the governance of health and safety matters. Our audit identified some issues concerning clarification of reporting arrangements between groups and also the lack of monitoring of health and safety training compliance. We have provided **Reasonable Assurance** for this objective.

Objective 4: Health & Safety risks are appropriately assessed and there is an up-to-date health and safety risk register in place.

2.28 There is no separate Health & Safety risk register within the Health Board. Any health and safety risks identified will be added to the relevant department's risk register and the risks will be manged in line with the Health Board's Risk Management Framework.

2.29 Each directorate is required to inform the H&S Group of any health and safety risks via their highlight report. Our review of the Directorate Highlight reports confirmed that these updates are taking place.

Conclusion:

2.30 Health and safety risks are 'owned' and managed by individual departments in accordance with Health Board guidance. Information on Directorates health and safety risks are submitted to the Health & Safety Group. We have provided **Substantial Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Health and Safety related policies and procedures (Operational)	**Impact**

The Health Board's main H&S policy also includes a list of supporting H&S policies and procedures. We undertook a review of these policies and procedures to confirm that they were in date and published on the Health Board's intranet.
 	
Our review noted the following issues:
 	
• The Control of Risks at Work to New Expectant Mothers Policy (HSP 010) and Control of Substances Hazardous to Health (COSHH) (HSP013) Policies have recently been reviewed and approved, however, they are yet to be published on the intranet.
 	
• We noted that the policy reference numbers listed in the main Health & Safety Policy for a number of supporting policies differed to the reference numbers of the policies that can be found on the Intranet:
  ○ EWP 015 Reducing False Fire Alarms – H&S Policy HSP021
  ○ EWP 016 Fire Risk Assessment Procedures & Guidance – H&S Policy HSP022
  ○ EWP 017 Arson Prevention Procedures – H&S Policy HSP023
  ○ EWP 018 Emergency Evacuation of Disabled Persons - H&S Policy HSP024
  ○ PTHB 018 First Aid at Work – H&S Policy PTHB 019
• FTP005 Security Protective Measures Policy was due for review in September 2023.
	Potential risk of:
	
	• Staff may be following incorrect advice.

Recommendations		Priority
1.1	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.	**Low**
1.2	Management should review the main Health & Safety Policy to ensure that the correct references are quoted for all supporting policies noted.	**Low**

Agreed Management Action		Target Date	Responsible Officer
1.1	Management will review the version control of relevant H&S policies and ensure they are updated in a timely manner	March 2024	Assistant Director Health and Safety and Support Services
1.2	Management will review and update the Health and Safety Policy so that it reflects the correct references for supporting policies.	March 2024	Assistant Director Health and Safety and Support Services

Matter Arising 2: Identification and Delivery of Training Requirements (Operation)	**Impact**
As part of the audit fieldwork, we undertook a review to ensure that health & safety training was being identified and delivered as per the Health & Safety policy. We identified the following issues: <u>Institution of Occupational Safety and Health (IOSH)</u> Appendix 4 of the Health & Safety policy references the different levels of IOSH training to be undertaken and which staff groups these levels apply to, as follows: • Leading Safely – This is a half day training course for Chief Executives and Executive Directors and sessions were scheduled for October and November 2023. • Managing Safely - This is a 3-day course aimed at Assistant Directors, managers/supervisors and team leaders. At the time of the audit this training was not taking place as the Health Board was unable to source a company to provide the training. • Working Safely – This a 1-day course aimed at all staff. Whilst the IOSH working safely training is a part of the Institute of Leadership and Management (ILM) training, not all staff will undertake this course Therefore, at the time of the audit the Health Board was unable to deliver all the training needs requirements of the IOSH. We were also unable to evidence any training records that were maintained for IOSH delivered. <u>Competency specific training</u> Where staff are required to use specialised machine tools, specific training will also be required as noted in the Health & Safety policy. At the time of the audit there was no 'database' in place for identifying these details. We do note however that a workforce review is currently being undertaken to identify competency specific training requirements and relevant courses. <u>Key H&S staff</u> The senior H&S officers provided IOSH working safely courses up to April 2023 for which they are required to undertake a professional body qualification. As part of their roles, they also attend a number of Health and safety related meetings. When querying the arrangements in place to ensure that these staff are appropriately trained with sufficient support, we were advised that there is currently no analysis of their training needs or matrix detailing what their training requirements are.	Potential risk of: • The Health Board does not have adequate health and safety training arrangements in place

Recommendations		Priority
2.1	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.	**High**
2.2	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.	**High**

Agreed Management Action		Target Date	Responsible Officer
2.1	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.	June 2024	Assistant Director Health and Safety and Support Services
2.2	Management to undertake a training needs analysis for staff identified as 'Key' Health and Safety Staff to ensure training requirements are identified and delivered.	March 2024	Assistant Director Health and Safety and Support Services

Matter Arising 3: Health and Safety Reporting to Health Board Committees (Operation)	**Impact**
In accordance with the Health Board's annual workplan the 2022/23 Health & Safety report should have been provided to the March 2023 Board Meeting. This did not take place and we have been unable to evidence if indeed the 2022/23 annual report was produced. We note that the 2023/24 Health & Safety Report is scheduled to be presented to the March 2024 Board meeting. Section 7 of the Health & Safety Policy relates to Communication and Consultation of Health & Safety Issues, Table 1 illustrates the process noting that the Health & Safety Group reports to the Executive Committee then Delivery & Performance Committee then Board. However, the TOR for the Health & Safety Group, which are outlined in section 7.1 of the policy, states that the group reports to the Patient, Experience, Quality & Safety Committee. Section 8 of the policy relates to Audits & Inspections with the process outlined in Table 2 highlighting that assurance reports from the Health & Safety Group will be submitted to the Patient Experience, Quality & Safety Committee. As part of our audit fieldwork, we were able to confirm that Health & Safety update reports were submitted to the Executive Committee and Delivery & Performance Committee meetings that took place in February and August 2023. We were not however able to confirm any reporting to the Patient Experience, Quality & Safety Committee.	Potential risk of: • The Health Board is unaware of issues concerning Health & Safety.

Recommendations		**Priority**
3.1	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.	**Medium**

3.2	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 policy.	

Agreed Management Action		Target Date	Responsible Officer
3.1	Management will establish an annual cycle for the delivery of the annual report	March 2024	Assistant Director Health and Safety and Support Services
3.2	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	March 2024	Assistant Director Health and Safety and Support Services

Matter Arising 4: Monitoring & Reporting of Training Compliance (Design)	**Impact**
The H&S group currently does not formally review or monitor all the levels of IOSH training. The H&S group's workplan helps drive the areas the H&S group should focus on from a strategic level. There is however currently no formal or proactive system in place which reviews mandatory and statutory training compliance, including low or high performing areas and undertaking follow up actions for the low complying areas. We do note that as of October 2023 the Departmental Highlight reports that are reviewed at the Health & Safety Group include information on Statutory & Mandatory compliance, although a number of issues have been noted regarding the information provided, which are noted in Matter Arising 5.	Potential risk of: • Staff do not receive appropriate training. • Management is not aware of poor areas of compliance.

Recommendations		**Priority**
4	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	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.	March 2024	Assistant Director Health and Safety and Support Services

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Matter Arising 5: Highlight Report (Operation)	**Impact**
At each meeting of the Health & Safety Group each department is required to provide a highlight report on health and safety matters. We note that a new template has been rolled out for the highlight reports with all departments required to provide updates on agreed themes including risks and incidents. The Health & Safety Group meeting that took place in October 2023 was the first meeting where the new highlight reports were submitted. The highlights reports were reviewed in order to have an understanding of the type of statutory and mandatory training information that was provided via the October highlight reports. We noted the following: • There was no standardised period of coverage across the Directorates highlight reports: • Some directorates were still using the old format either alone or alongside the new format: and • The mandatory & statutory training compliance rates were presented in a number of ways. Some were presented by the category of staff, departments, courses or the provision of one compliance figure for the whole directorate.	Potential risk of: • Information from the highlight report is not clear.

Recommendations	**Priority**
5 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.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**

5	Management will introduce a standard format for the reporting of mandatory and statutory training	March 2024	Assistant Director Health and Safety and Support Services

Matter Arising 6: Governance Arrangements within Health & Safety Subgroups (Operation)	**Impact**
We undertook a review of the subgroups of the Health & Safety group to ensure that they were operating as per their ToR. We noted the following issues: <u>Fire Safety Group</u> The ToR states the Fire Safety group is expected to report to the Executive Committee and the Board, whilst Page 24 of the Health & Safety policy has a reporting diagram (with dotted lines) which shows the fire safety group reporting to the H&S group. <u>Security Oversight Group</u> The Security Oversight Group is required (as stated in its ToR) to provide a quarterly highlight report to the Health and Safety Group, however apart from the January 2023 meeting where we were advised that a verbal update had been given, we have been unable to evidence any updates submitted to later meetings. <u>Site Coordination Forum</u> The Site Coordination Forum ToR were due for review in February 2023, but the review is yet to take place. According to the ToR the frequency of the meetings is bimonthly, however our review of the meetings that took place in 2023 noted that whilst meetings took place in January and July those scheduled for March and May did not take place. We understand that the reason for this was due to a change in management arrangements due to the departure of Senior Management.	Potential risk of: • The Health Board does not have adequate health and safety arrangements in place.
Recommendations	**Priority**

6	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.	**Low**

Agreed Management Action		Target Date	Responsible Officer
6	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	March 2024	Assistant Director Health and Safety and Support Services

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Incident Management
Final Internal Audit Report

January 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

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Executive sign-off:	Claire Roche - Director of Nursing and Midwifery
Distribution:	Zoe Ashman – Assistant Director of Quality and Safety Heidi Sinclair – Head of Quality and Safety
Committee:	Audit Risk & Assurance Committee

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

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Health Board's Incident Management Framework (June 2023) adopts the latest national guidance for managing incidents.
- Further engagement is required between the Quality and safety Team and Service Areas to better coordinate and further implement the incident management training programme.
- The Mental Health Service Area are dealing with a significant backlog of open incidents which have been dealt with and just awaiting finalisation/closure within Datix.
- Further work is required to ensure that lessons learnt from incidents are being monitored and actioned.
- Improvements required to ensure Nationally Reportable Incidents are reported within the required timescales.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.	 Incident Management (PTHB-2223-06)

Assurance summary[1]

Objectives		Assurance
1	Incident management policies and procedures	Reasonable
2	Incident identification, recording and responsiveness.	Limited
3	Incident monitoring and reporting	Reasonable
4	Incident lessons learnt	Reasonable
5	External incident reporting (Nationally reportable incidents)	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Incident reporting training	1&2	Operation	Medium
3	Incident reporting and management timeliness	2&3	Operation	High
4	Monitoring of actions arising from incident investigations	4	Operation	Medium
5	Nationally Reportable Incidents timeliness	5	Operation	Medium

1. Introduction

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

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

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

1.4 The Health Board has a revised Incident Management Framework in place which was approved in July 2023. Implementation of the Framework will further support the timely and robust management of incidents.

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

1.6 We previously carried out a review of Incident Management as part of the 2022/23 Internal Audit plan. The final report was issued in March 2023 with an overall rating of Reasonable Assurance. The 22/23 review focused on processes within the Community Services Group, the current review has focused on Women and Children Services and Mental Health Services.

1.7 The Executive Director of Nursing is the executive Lead for the review.

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

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

2. Detailed Audit Findings

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

2.1 National incident reporting in NHS Wales underwent major changes from 14 June 2021 with the publishing of Phase 1 of the National Patient Safety Incident Reporting Policy by the Welsh Government. The NHS Wales National Incident Reporting Policy Implementation Guidance Document (Phase 1) was coordinated and produced by the NHS Wales Delivery Unit for use by all NHS Wales Organisations, supporting how NHS Wales responsible bodies will implement the Welsh Government's National Incident Reporting Policy.

2.2 In May 2023, the NHS Wales Executive published a revised National Incident Policy and Guidance document. Through the updated version of the Policy, the NHS Wales Executive has developed further on the initial aims (June 2021 policy) continuing to promote collaborative work between NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analyzing incident data.

2.3 The Health Board's SharePoint site has a Quality and safety section which includes Health Board, Welsh Government and the Delivery Unit's policy, guidance documents, training updates, forms and templates. Our previous internal audit of the Health Board's incident management arrangements (see paragraph 1.6) made a recommendation relating to the number of incident management policies and procedures requiring review and update. We can confirm that the Quality and Safety Team has implemented this recommendation by combining all policies and procedures into one overarching Incident Management Framework ('the Framework') which was published in June 2023.

2.4 Our review of the Framework, which is available to all staff via the Quality and Safety section of the Health Board's intranet (SharePoint), confirms that the document aligns with the latest NHS Wales Executive national policy and Delivery Unit guidance on the management and reporting of incidents. We did note however, that there is one area of the National guidance which is not clearly set out within the Framework. **(Matters Arising 1 – Low Priority)**

2.5 As part of the scope for the audit, we considered the incident management arrangements locally for two Service Areas:

- Women and Children;
- Mental Health.

We met with governance and clinical leads for both areas and sighted various documentation (Standard Operating Procedure (SOP), flowcharts, policies and procedures) which confirmed alignment with the overarching Framework.

2.6 The Quality and Safety Team, supported by the Safety Systems and Information Coordinator deliver incident reporting and management training seminars twice monthly. These sessions are open to all staff who wish to attend and can register via the "Datix Training" section on the Quality and Safety page on the intranet (SharePoint).

2.7 As per paragraph 2.14, analysis of the incident data and findings from our sample testing of incidents logged on Datix system identified a high number of instances where staff have misclassified the levels of harm. Discussions with the Quality and Safety Team and with the respective governance leads from both sampled service areas confirmed that these are long standing issues which have been known to the Health Board and actions are being taken to ensure that there is a coherent and consistent understanding amongst staff of how to assess level of harm. As per paragraph 2.6, there is a training programme in place for new and existing users. In addition to this, as part of the Incident Management Framework implementation, the Q&S team will be reviewing the RCA framework and its implementation in line with the Patient Safety Incident Response Framework (PSIRF, NHS England). **(Matters Arising 2 – Medium Priority)**

2.8 The Quality and Safety Team are also in the process of reviewing training and support provided to teams in the event of a patient safety incident, to include walk-through of the incident, statement writing, support with Coroner's Court and debrief following this.

Conclusion:

2.9 The Health Board has developed a comprehensive Incident Management Framework (June 2023) which aligns to WG policy and NHS Wales Executive guidance. The Framework is supported by a plethora of SOPs, templates and guidance procedures all of which are accessible via the intranet. The Health Board needs to continue to progress with its Datix training programme to ensure compliance with the Framework and accurate use of Datix. We have provided **Reasonable Assurance** for this objective.

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

2.10 In line with national guidance, the Health Board has implemented the "Once for Wales Concerns Management System" and records all patient safety incidents via the Datix module. To inform the review, we were provided with read only access to the incident database relating to the two sampled service areas; Mental Health and Women and Children.

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

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

2.13 When initially logged on Datix incidents are assessed by the reporter (staff logging the incident) as either: no harm; low harm; moderate harm; severe harm; or

death. Investigations into reported incidents are managed by the governance team within each of the service areas and overseen by the Quality & Safety Team. Depending on the level of harm, staff are allocated responsibility for managing and investigating the incident case. For example, a low harm case is managed by operational management, while significant cases, whilst still being investigated within the service areas, will also involve the Quality and Safety team.

2.14 As per the scope of the audit, we performed an analysis of the Datix database for the two sampled areas. The dataset focused on incidents that had occurred between 1st April 2023 and 15th November 2023 with a "closed" status. The analysis considered the timeliness of incident initial reporting, management response, investigation and closure. Several observations were made:

- Whilst all incidents reviewed were in the "Low/No Harm" category, stages within the incident reporting and management process fell behind expected and established timelines. **(Matters Arising 3 – High Priority)**
- The reporter's assessment on the level of harm is often re-graded following management review/investigation. **(See Matters Arising 2)**
- Within the Women and Children Service Area, a large proportion of low/no harm incidents is being directed to the Women and Children Risk and governance Lead for "Management Review/Make Safe". As per paragraph 2.13, these incidents should be assigned to operational management. The disproportionate assignment of incident caseloads is a likely cause of the Women and Children Service Area falling behind incident reporting and management expected and established timelines. **(See Matters Arising 3**)
- Mental Health Service Area is currently dealing with a significant backlog of open incidents, the majority of which has a low/no harm impact and need to be closed. The Quality and Safety Team are undertaking regular training to address this issue (See paragraph 2.7)

2.15 In addition to the analysis of the Datix system we also selected a random sample of 20 closed incidents from across the two samples areas (10 each). Records and documentation stored to Datix confirmed the following:

- Assignment of responsible individuals for undertaking Management reviews/investigations;
- Evidence of near immediate "make-safe" actions taking place in all cases;
- Evidence of lessons learnt and action plans being in place (where investigations had been completed).

Conclusion:

2.16 Our data analysis demonstrates that key stages within the incident reporting and management process are currently falling behind the expected and established timelines. In particular for the Mental Health Service area, which is also dealing with a significant backlog of open and overdue incidents. We have provided **Limited Assurance** for this objective.

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

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

2.18 We can confirm that the data dashboards are readily available to all staff and are fully customisable at the request of the Safety systems and Information Co-ordinator. We also note that the Head of Quality and Safety monitors all open and overdue incidents across the Health Board and sends weekly emails to operational and senior management of the relevant Service Areas to promote timely closure and actioning of open incidents.

2.19 The Health Board's Integrated Quality Report (IQR), which is presented to the Executive Committee and to the Patient Experience, Quality and Safety Committee includes a serious incidents and concerns section. The reports for April, July and October 2023 were reviewed, the relevant areas of the report pertaining to the audit included:

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

2.20 The Professional Nursing and Midwifery Oversight Group, which meets monthly and reports into the Patient Experience, Quality and Safety Committee, is a forum that provides assurance on Nursing Quality and Safety. Each Service Area provides a Quality Assurance Report on a number of themes, one of which is incident management. A review of the Quality Assurance Reports submitted in September, October and November 2023 confirmed that the following data is produced:

- Number of Nationally Reportable Incidents in the period;
- Update on serious patient safety/Duty of Candour incidents;
- Trends of incidents being submitted (year view);
- Breakdown of the categories of incidents submitted in period; and
- Breakdown of "Open Incidents" with an update as to where the service area is at ensuring completion.

2.21 We also reviewed the governance arrangements in place for the sampled Service Areas and can confirm that there are appropriate structures and reporting arrangements in place to discuss and escalate incidents (where applicable). We did note that there is limited scrutiny of the Datix data (open/overdue incidents

awaiting action, incident reporting and management performance). **(See Matter Arising 3)**

Conclusion:

2.22 The Health Board has a structure in place that provides effective mechanisms for incident reporting from a Service Area level up to the Quality and Safety Team and up to the Patient Experience, Quality and Safety Committee and the Board. Whilst the regularity of the current monitoring arrangements allows for the prompt escalation of incidents, further work is required to ensure that incident reporting and management data from Datix is routinely visible to operational management. We have provided **Reasonable Assurance** for this objective.

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

2.23 The Incident reporting form on Datix has a section where lessons learnt are to be documented. Depending on the level of harm and type of incident, the completion of the lessons learnt section might not be applicable. We selected a random sample of 20 recently completed investigations (10 from each Service Area) and can confirm that for all completed investigations in our sample, the lessons learnt had been captured. However, the action plan section within Datix was not completed and there was limited information available to confirm whether the actions had been completed. **(Matters Arising 4 – Medium Priority)**

2.24 Listening and learning events regularly take place within the Mental Health and Women and Children service areas. We saw that key themes and trends from high profile incidents are discussed and lessons learned with best practice guidance shared amongst staff in attendance.

2.25 The Quality and Safety Team produce quarterly newsletters providing information such as staff incident related training dates, key patient safety learning and actions, urgent safety briefings and safety alerts. Majority of the information is added to the Quality and Safety Section of the Intranet (SharePoint)

Conclusion:

2.26 Lessons learnt are documented on Datix and shared via a number of means at the Health Board level from reports presented at the PEQS to the learning newsletters and 7-minute briefs. Methodical sharing has been evidenced at the operational level within both Mental Health and Women and Children Service Areas. However, we have found that there is a lack of documentation to support the monitoring of action plans arising from incident investigations. We have provided **Reasonable Assurance** for this objective.

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

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

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

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

2.30 Performance in relation to Nationally reportable incidents from each Service Area are reported monthly to the Professional Nursing and Midwifery Oversight Group, to the Patient Experience, Quality and Safety Committee and to the Executive Team/Board. A review of the governance documentation for November 23 confirmed the there are currently 19 NRI's with an open status. Of the total, 7 relate to Mental Health Service area and 1 relates to Women and Children.

2.31 We performed a review of the NRI's with an open status as at November 2023 and can confirm that the Health Board has experienced delays in reporting 3 of the 8 NRI's that related to Mental Health Service and Women and Children. The reason for the delay in submission were noted within the Datix system and were reviewed and approved by the Executive Director of Nursing and Midwifery. All incidents remain open and have agreed "finalisation by" dates by NHS Wales Executive. A review of the monthly reporting confirms that updates on the progress of open/overdue NRI's are being provided to the PNMOG. **(Matters Arising 5 – Medium Priority)**

Conclusion:

2.32 The findings from our sample testing (incidents and Nationally Reportable Incidents) together with findings from our data analysis of the Datix system suggest that further work is required to ensure that incidents and Nationally Reportable incidents are reported in a timelier manner. The Health Board is aware of this and regular updates on incident management progress are being shared with Senior Management through the governance structure. We acknowledge that the Health Board has recently implemented a revised Incident Management Framework in July 2023 and that it will take time to fully implement and embed improvements to incident reporting processes. **Reasonable Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Incident Management Framework (Design)	**Impact**
In May 2023 the NHS Wales Executive published a revised National Incident policy and guidance document. Our review of the Health Board's Incident Management Framework found that it aligns to WG, NHS Wales Executive national policies and DU guidance. However, we did note that there is an area within the DU guidance that is not clear within the Health Board's Incident Management Framework (July 2023) - "Setting out the reporting lines into relevant committees and the Board". The NHS Wales National Incident Reporting & Management Policy sets out the requirement for clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board. Although our review of the monitoring and reporting of incidents has identified that the Board and relevant committees are sighted on this information, the Incident Management Framework does not make reference to how reporting will take place.	Potential risk of: • Non-compliance with the most relevant legislation.

Recommendations		**Priority**
1	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.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Update the Incident Management Framework to reflect the Health Board governance arrangements for the management of Nationally Reportable Incidents.	February 2024	Head of Quality & Safety

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Matter Arising 2: Incident Management Training (Operation)	**Impact**
Our data analysis of the Datix system noted that for a significant number of incidents (that had been closed and thus were subject to management review/investigation), the level of harm was incorrectly assessed by staff reporting the incidents. Our findings concluded that between April 2023 and November 2023 the following number of incidents were regraded: • Women and Children – 35 incidents of a total of 141 – 25%. • Mental Health – 65 incidents of a total of 104 – 63%. We note that following management review/investigation the above incidents were graded to low/no harm. We reviewed a random sample of incidents which were regraded and can confirm that the rational for changing the level of harm was justified and thus the incidents fell into the low/no risk category. Discussion of the above findings with senior management from both service areas confirmed a general consensus that this is a training issue.	Potential risk of: • Non-compliance relevant incident reporting and management requirements.

Recommendations		**Priority**
2	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	Governance leads for service groups to complete a training needs analysis to highlight staff members that have not completed Datix Incident Management training.	March 2024	Governance Leads:

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Matter Arising 3: Incident reporting and management timeliness (Operation)	**Impact**

We performed an analysis of the Datix database for the two sampled areas. The dataset and range was limited to incidents that had occurred within the current financial year to date (1st April 2023 to 15th November 2023 and with a "closed" status. The analysis considered the timeliness of incident initial reporting, management response, investigation and closure.

To note that within this period, there were no closed incidents, which following management review/investigation, were assessed as having a level of harm which was moderate or above.

Women and Children Service Area (Between 1st April 23 and 15th November 23 – total of 141 incidents closed) Indicators	**Expected and established timelines**	**Low/No Harm** (Average days taken by Health Board)	**Notes**
Average days to report incident within Datix from incident occurrence	Within 1 day	**8 days**	Note 1
Average days for incident to be at Management review stage (Make it Safe plus)	Within 2 days	**18 days**	Note 2
Average days for investigation to complete	Within 24 days	**18 days**	Within timescales
Average days for incident to be closed (overall cycle)	Within 29 days	**22 days**	Within timescales

Note 1: Midwiferies Cynefin and Midwifery Dylife the worst performers taking on average 18 and 13 days respectively to report Datix incidents from the incident date.

Note 2 Further analysis found that within the Women and Children Service Area, a large proportion of low/no harm incidents is being directed to the Women and Children Risk and governance Lead for "Management Review/Make Safe". As per paragraph 2.13, these incidents should be assigned to operational management.

Potential risk of:

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

This disproportionate caseload assignment is a likely cause of the Service Area falling behind the above expected and established timelines.

Mental Health Service Area (Between 1st April 23 and 15th November 23 – total of 104 incidents closed)	**Indicative Timescales**	**Low/No Harm**	**Notes**
Indicators			
Average days to report incident within Datix from incident occurrence	Within 1 day	**3 days**	Note 3
Average days for incident to be at Management review stage (Make it Safe plus)	Within 2 days	**16 days**	Note 4
Average days for investigation to complete	Within 24 days	**21 days**	Within timescales
Average days for incident to be closed (overall cycle)	Within 29 days	**37 days**	As per note 4

Note 3: 20 incidents took on average 6 days to be reported and the likely cause for skewing this indicator.

Note 4: Discussions with the Head of Nursing – Quality and Safety and with the Lead Clinician – Quality and Safety confirmed that the Service Area has and continues to deal with operational pressures and capacity challenges which are having a knock-on effect on other processes such as the timely management and closure of incidents within Datix. As at the 15th November 2023, there were 179 open incidents within Datix for Mental Health Service area of which:

- *2 incidents had been reviewed and investigated and were awaiting closure;*
- *175 incidents were at Management Review stage. Of the total, 134 had elapsed the 29 days overall turnaround time and were considered "overdue". Discussions with the leads confirmed that the majority of these incidents had been reviewed and were of low/No harm and needed closing.*
- *2 incidents were under investigation.*

Similar incident reporting and management issues were also identified as part of last year's internal audit review (see paragraph 1.6) which focused on Community Service Groups.

Open and overdue incidents are also discussed at the Professional Nursing and Midwifery Oversight Group (PNMOG), which meets monthly and is chaired by the Executive Director of Nursing and Midwifery and attended by Service Area leads and the Quality and Safety Team. A review of the PNMOG which met in November, confirmed that the Health Board is aware of the current levels of open/overdue incidents and as of September 2023, the Datix notification system has been amended so that staff with allocated open/overdue incidents are notified. The Quality and Safety Team have been tracking the trends of open incidents and have noted a significant improvement in October 2023 with a 157% increase in incident owners investigating and closing incidents.		
Recommendations		**Priority**
3	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.	**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
3 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.	March 2024	Respective Heads of Nursing and Midwifery

Matter Arising 4: Monitoring of Actions from Lessons Learnt (Operation)	**Impact**
The lessons learnt section on the incident reporting form on Datix is usually completed and is documented based on the uniqueness in learning of the reported event. Depending on the type of incident, the completion of the lessons learnt section might not be applicable. Evidence from reviewing the Directorate of Nursing and Midwifery and Health Board reports, shows synopsis in the identification of lessons learnt. Listening and learning events regularly take place within the Mental Health and Women and Children service areas. We saw that key themes and trends from high profile incidents were being discussed with lessons learned and best practice guidance being shared amongst staff in attendance. However, we noted that there is currently no form of monitoring (on one system/ database) of the lessons learnt over time and actions which have been undertaken operationally to minimise future occurrence where these deficits are identified. This issue was also identified as part of last year's incident management audit.	Potential risk of: • Non-compliance with relevant legislation. • Patient harm or poor patient experience. • Reputational damage with decreased public confidence.

Recommendations		**Priority**
4	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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Services to review systems in place to monitor lessons learned to support appropriate triangulation and improvement.	May 2024	Respective Heads of Nursing/Midwifery

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Matter Arising 5: Nationally Reportable Incidents (Operation)	**Impact**
The Quality and Safety Team reports on status of open Nationally Reportable Incidents on a monthly basis to the Professional Nursing and Midwifery Oversight Group. We reviewed the latest NRI report presented to the Group in (November-23) and can confirm that progress of NRI's is being monitored with actions agreed to ensure that the stages for reporting NRI's are being undertaken. As at November 2023 there were 19 NRI's with an open status for which 7 related to Mental Health Service area and 1 related to the Women and Children Service area. Further investigations of the Datix system confirmed that 3 of the open NRI's that related to the Mental Health Service area had not been reported to the NHS Wales Executive in a timely manner. We also noted that one of the open NRI's for Mental Health Service Area (ref:3944), which occurred in April 2022, is yet to be reported to the NHS Wales Executive. The Quality and Safety Team and the Management from Mental Health service area are currently in the process of retrospectively reporting the incident to the NHS Wales Executive. We acknowledge that the issues above relate to incidents that had occurred prior to the implementation of the Incident Management Framework (June 2023) and that the recently established PNMOG, which is attended by the executive Director of Nursing and Midwifery, will continue to monitor open NRI and their submissions on a monthly basis.	Potential risk of: • Non-compliance with relevant legislation. • Patient harm or poor patient experience. • Reputational damage with decreased public confidence.

Recommendations		**Priority**
5	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).	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5	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.	January 2024	Assistant Director of Quality & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Information Governance
Final Internal Audit Report

November 2023

Powys Teaching Health Board

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

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

Contents

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Executive sign-off:	Pete Hopgood (Executive Director of Finance, Information & IT Services)
Distribution:	Vicki Cooper (Assistant Director – Digital Transformation and Informatics), Amanda Smart (Head of Information Governance, Records & Data Protection Officer)
Committee:	Audit Risk & Assurance Committee

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

Overview

We have issued **limited** assurance on this area. The significant matters which require management attention include:

- insufficient resourcing to undertake all IG duties;
- lack of wider IG structure within the Health Board to engage IG and support the IG team;
- information asset owners not identified in all service areas, and information asset register only partially progressed; and
- inadequate frequency of reporting arrangements.

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Sufficient resources to undertake IG function	Limited
2	Appropriate structure to engage and comply with all areas of IG	Limited
3	Appropriate governance structure	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IG Team Resources	1	Design	High
2	IG Structure	2	Design	High
3	Information Asset Register	2	Design	Medium
4	IG Reporting Arrangements	3	Operation	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for the Powys Teaching Health Board (the Health Board), a review of the management of Information Governance was undertaken.

1.2 Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently, and effectively, in order to deliver the best possible healthcare and services.

1.3 Key legislative requirements related to IG are identified within:

- UK Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR); and
- Freedom of Information Act (FoIA).

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

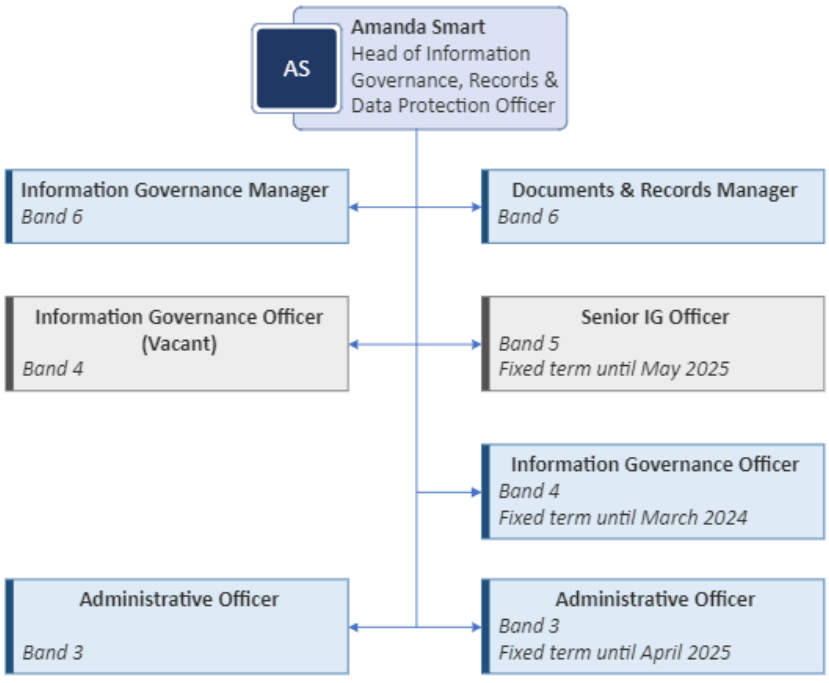
1.5 The potential risk considered in the review is as follows:

- Non-compliance with legislation.

2. Detailed Audit Findings

Objective 1: There are sufficient resources in place to enable all IG duties to be undertaken effectively.

2.1 At the time of this review, the Health Board's IG structure is depicted as below:



2.2 In line with UK GDPR, the Head of IG and Records (HoIGR) is the appointed Data Protection Officer (DPO) and is responsible for ensuring the Health Board meets its legislative and statutory duties through the governance of both IG and Records Management functions. Whilst operational responsibility for corporate and clinical records sits with services, the strategic development of the Health Board's approach to Record Management comes under the remit of the HoIGR. This includes the Records Management Improvement Plan (RMIP), created, and adopted by the Health Board's Audit, Risk and Assurance Committee in November 2019 in response to the 'No Assurance' Internal Audit Report of the same year (PTHB-1920-17 Records Management).

2.3 We note that the Health Board has recognised the importance of Information Governance and the staffing of the function has been increased to reflect this. However, as discussed below, the Health Board has been subject to increasing numbers and complexity of requests for information which has eroded the effect of the additional resource provided.

2.4 We reviewed the IG team structure and documented roles and responsibilities of team members, which highlighted substantial workloads. We note that the HoIGR currently has managerial responsibilities for all team members, and positive steps have been taken to explore the opportunity to delegate the responsibility of junior staff to the Senior Officer and Managers. We consider the current structure, inclusive of fixed term contracts and one vacancy, to offer little resilience in the service. Whilst resourcing has increased since the beginning of the pandemic, 50% of the IG team are on fixed-term contracts, which presents a continuous challenge to build a cohesive team and places further demand on the team to re-recruit and re-train new staff in the immediate future. We understand that due to the knowledge required to undertake IG roles, it can take upwards of six months to successfully embed into the team.

2.5 The HoIGR is a member of the NHS Wales Information Governance Management & Advisory Group (IGMAG), and the IG team are involved in all national and local programmes and projects involving personal data as evidenced by their programmes of work register, to ensure that potential incident risks to the Health Board are identified and resolved. It is important to note that numerous tasks within the IG team's remit are received on an ad-hoc basis, are time-limited and time-consuming, with the potential for substantial penalties if breached. Whilst not exhaustive, we have outlined below some of the more significant tasks undertaken by the IG team in addition to Access to Information requests, which are covered in detail under sections 2.14-2.24.

- investigating personal data breaches and reporting above-threshold incidents to the Information Commissioner's Office (ICO) within 72 hours;
- processing Medical Examiner Service requests within 72 hours of a death occurring;
- processing requests for Erasure or Rectification within one calendar month;
- processing Access to Information requests within 20 – 40 days;
- processing Court orders;

- completing Data Protection Impact Assessments (DPIA) for any project requiring the processing of personal data;
- completing Data Sharing Agreements;
- creating and delivering bespoke training for Health Board services; and
- NHS Wales Information Governance Toolkit for Health boards and Trusts.

2.6 The IG Team has a workplan in place. This sets out the foundational activities and work needed to develop the structures and processes within the Health Board to enable compliance with legislation and ensure good information governance is maintained going forward.

2.7 Our assessment of the IG team's current and forecasted workplan identified that resource levels are not sufficient to meet all demands from the service. We note that the workplan captures improvement and development actions which, whilst not being a legislative requirement, are actions that seek to improve information governance within the organisation. The workplan is RAG rated to demonstrate progress against duties and we observed that 11.5% of tasks are being achieved, 50% are barely being achieved and 38.5% have not been started and/or are not being achieved, which include the following:

- Policy and procedure review;
- Records Management Improvement Plan;
- Destruction of Records project;
- Digitisation of Records project;
- Information Asset Register;
- Privacy Notice for Children;
- Account Control 3 Audits;
- Record of Processing Activities (ROPA) Register;
- Auditing;
- General Information Governance and Records related guidance; and
- Professional Development.

2.8 We noted that team capacity is cited as one of the main reasons for not achieving progress with the above tasks, although we note that funding is also a constraining factor for some, e.g., the Digitisation of Records project. Capacity has also been identified as a risk to respond to requests within legislative timescales and included on the Digital Transformation Risk Register. Risk IG02, which has a current high risk rating of 9, was added to the register in June 2021. The mitigating action against risk IG02 is to undertake a review to identify additional resources required, however, we note that the risk has not been updated since August 2022. Whilst the IG team have an active workplan, it does not capture the complexity nor the time it takes to complete each task, therefore, there is a continued risk that resources required to undertake the IG function effectively, have not been fully quantified.

2.9 As observed in other Health Boards, whilst the pandemic promoted the importance of good information governance, a surge in demand of the IG team ensued as they received high volumes of requests for support to mitigate issues and risks arising from the rapid enactment of new digital ways of working, which included DPIAs,

Information Sharing Protocols (ISPs) and supplementary Privacy Notices. The IG team also received an increased number of requests for information exercising their rights from both the public and staff. We note from IG Key Performance Indicators (KPIs) regularly presented to the Delivery and Performance Committee (DPC) that the IG team continue to receive high volumes of requests, however, they do not portray the upward trend of receiving increasingly complex requests, the length of time required to resolve or level of resource available to handle them.

2.10 Factors adding to the complexity of a request may include:

- technical difficulties in retrieving information – for example if data is electronically archived.
- applying an exemption that involves large volumes of particularly sensitive information.
- clarifying potential issues around disclosing information about a child to a legal guardian.
- any specialist work involved in obtaining and/or redacting information or communicating it in an intelligible form.
- coordinating/meeting with service leads in a timely manner.
- reading and understanding current legislation and how it can be applied to complex requests.

2.11 The absence of this detail provides an inadequate representation of the IG team's current and future capacity. A full assessment of the resources available to undertake all IG-related duties is required to enable effective gap analysis, upon which capacity and resilience can be measured. We acknowledge from our meeting with the HoIGR, that recording time against duties is challenging due to already demanding workloads and options are currently being explored with the Digital Transformation Team to find a way forward. **See Matter Arising 1 at Appendix A.**

2.12 The recently appointed Documents and Records Manager was recruited to play a key role in coordinating the ongoing design and delivery of a robust Records Management Framework by progressing the Records Management Improvement Plan (RMIP). However, we noted that they are also greatly involved in supporting other statutory duties such as FOI requests and SARs, therefore, advancement of the framework has been hindered. Our review of the RMIP update report provided to the DPC on 23 June 2023, highlights significant progress is still to be made against the plan as indicated below:

Recommendation	Progress %	RAG Status	Start Date	End Date
Accountability, leadership, and coordination of records management	100			
Strategies, Policies and Procedures	50		May-22	Dec-22
Identification and Tracking of Records	40		Mar-22	Mar-23
Security of Records	30		Mar-22	Dec-22
Storage of Records	30		Mar-22	Dec-22
Risk Management	60		May-22	Dec-22

2.13 The current IG structure and present ways of working provide a challenge to maintain conformance with legislative responsibilities across multiple areas, including Access to Information requests, and to progress programs of work such as the Information Asset Register (IAR) (See Objective 2). This has impacted upon the Health Board's ability to meet strategic requirements to develop, implement and embed robust arrangements to effectively manage and protect its information assets.

Freedom of Information Act (FoIA)

2.14 Anyone has a right to request information from a public authority. Organisations have two separate duties and up to 20 working days when responding to these requests:

- to tell the applicant whether they hold any information falling within the scope of their request; and
- to provide that information.

2.15 Organisations responding to fewer than 90% of requests within 20 working days, are classed as 'unsatisfactory' by the Information Commissioner's Office (ICO). Whilst there are currently no monetary penalties for breaching FoIA, in 2022 the ICO announced that it would be delivering more systematic enforcement action against public authorities with consistent poor performance in responding to FoI requests. From our review of figures presented to the DPC, which are included in the below table, the Health Board is at risk of ICO monitoring and possible remedial action.

	Number of FOI Requests	Number of FOI breaches	% FOI Compliance
2021			
Qtr2	77	29	62
Qtr3	86	8	91
Qtr4	84	25	70
2022			
Qtr1	82	25	70
Qtr2	83	22	73
Qtr3	124	42	66
Qtr4	102	15	85
2023			
Qtr1	113	18	84
Grand Total	**751**	**184**	**75**

Subject Access Requests (SARs)

2.16 Patients, staff and third parties have the right to ask the Health Board whether they are storing personal data, what information is held, how they are using it, who are they sharing it with, where the data was obtained from, and to receive

copies of all relevant data. The request can legally be received by any member of the Health Board at any time, and can be in writing, verbally or through social media. The request does not need to include any reference to the phrase SAR or to data protection legislation.

2.17 The Health Board must respond to requests within one month. This can be extended to a maximum of three months if several requests have been made and/or the request is complex, provided a clear explanation is given to the requestor.

2.18 Data protection legislation is regulated by the ICO and stipulates several actions that need to be adhered to when responding to a SAR, including searching for relevant information and redaction. Personal data is increasingly kept electronically as well as on paper, therefore searches need to be conducted across many sources, including e-mails, Microsoft Teams, WhatsApp, SMS, clinical systems, health records, hard drives (work and home), tablets, portable memory sticks, voice recordings, social media posts and CCTV files. Once all the information has been identified, data protection legislation requires appropriate clinical / healthcare professional scrutiny, redaction, and approval prior to its release.

2.19 The IG team is responsible for managing SARs in their entirety a well as other third-party requests such as police requests, including communicating with requestors and liaising with service representatives to supply the requested information and coordinate the responses. Redactions may be necessary to avoid the disclosure of third-party information from an individual's record. It is the responsibility of the reviewing clinician or service lead to identify information for redaction to the IG team as part of the internal process, however, we learned from our meeting with the HoIGR that the IG team are increasingly having to double-check clinical / healthcare input and redaction work prior to its release due to a lack of attentiveness, which is putting further strain on the team. This is of particular concern as redaction failings and/or erroneous disclosure of information are reportable ICO breaches. A serious breach of this nature recently occurred in another NHS Wales organisation, whereby one SAR disclosure included personal information pertaining to 7 other data subjects, which was subsequently reported in the press. The repercussions of these failings were significant and led to patient and wider family distress, patient safety concerns, financial compensation, formal complaints, ICO investigation and damage to the organisation's reputation.

2.20 The ICO has the power to issue an enforcement notice or monetary penalty should a UK GDPR breach occur. The higher maximum amount is £17.5 million or 4% of the total annual worldwide turnover in the preceding financial year, whichever is higher, or the standard maximum will apply if there is an infringement of other provisions, such as administrative requirements of the legislation, which is £8.7 million or 2% of the total annual worldwide turnover in the preceding financial year, whichever is higher.

2.21 The below table and graph capture the number of SARs received and breached over the last three years. We note that overall compliance has declined year on year, which exposes the Health Board to potential ICO scrutiny.

Year	Requests	Breaches	Compliance
2020/21	422	42	90%
2021/22	369	63	83%
2022/23*	465	38	81%

**Figures up to 29 March 2023 due to reporting cycle.*

2.22 Whilst none of the breaches were reportable to the ICO on this occasion, the Health Board should ensure that internal delays in responding and/or approving requests for information are addressed and improved.

Conclusion:

2.23 Whilst the pandemic promoted the importance of good information governance, it resulted in the IG Team receiving sustained high numbers of often complex and time-consuming statutory requests, which has created a significant challenge to adequately manage all requirements of the IG function. We acknowledge that resourcing has been strengthened over the last few years, however, building a cohesive team of fixed-term staff capable of managing the rise in number and complexities of statutory requests to satisfactory levels is challenging. Newly appointed staff require thorough training whilst the team as a whole must maintain conformance with duties. There is a mounting challenge to adequately manage responsibilities across areas such as FoI and SARs, as evidenced by below-threshold compliance rates, as well as maintain progress with non-core functions and meet strategic requirements to develop IG arrangements. Furthermore, there is a potential risk to the wellbeing of the IG team if the time-pressured demand is sustained with current capacity. Consequently, we have concluded **Limited** assurance for this objective.

Objective 2: There is an appropriate structure within the organisation to ensure all areas are engaged and comply with IG.

2.24 NHS Wales has a national IG Policy, with which the Health Board is generally compliant. Our review of the local IG structure confirmed that the key roles defined within the policy have been appropriately assigned as below:

Chief Information Officer	Chief Clinical Information Officer
Senior Information Risk Owner	Executive Director of Finance, ICT and Information Services
Caldicott Guardian	Executive Medical Director
Data Protection Officer	Head of Information Governance and Records

2.25 The Health Board has an IG Strategy and Implementation Plan, however, it is outdated, covering the period of 2015 – 2018 and has not been reviewed since June 2018. We note that it has been on the IG workplan since 2019, however, due to capacity challenges (linked to Matter Arising 1), this work has not been progressed.

2.26 The Health Board has an Information Asset Register (IAR) that was developed and deployed to support the launch of the UK GDPR in 2018/19. However due to the IG team at that time consisting of only two part-time members of staff, Information Asset Owners (IAO) and Information Asset Administrators (IAA) were not adequately identified in all areas of the organisation, and the launch was taken through the IG Champions Group which has since been stood down. Whilst the IAR template has recently been modernised to be hosted on Microsoft SharePoint and some areas within the Health Board are engaged with updating their information, the content has not been fully reviewed by the IG team due to the level of demand to perform other IG duties.

2.27 IAO should be responsible for ensuring that all information held by their service area is used and managed effectively, efficiently, securely, responsibly, and legally, regardless of format. To do this, IAO responsibility needs to be formally assigned in all areas of the Health Board. **See Matter Arising 2 at Appendix A**.

2.28 As required under the UK GDPR, organisations must protect their information assets. In order to effectively do this, they need to know what information they hold, if it's correct and up to date, who it's shared with and how it's processed. The IAR should be reviewed and progressed by each service area as a tool to track this information and not only show what information is held where, but to also map out the information flows to ensure there are appropriate security measures and controls in place based on how information moves around. **See Matter Arising 3 at Appendix A**.

2.29 We positively note that the HoIGR is currently engaged with the Health Board's Business Intelligence Team to ascertain whether the IAR could be moved into an O365 application and subsequently link in with the Systems Asset Register.

Conclusion:

2.30 Whilst the Health Board has mechanisms for engaging its employees with IG, the absence of IG Leads / Champions within the organisation places demand on the IG team to perform tasks that could be delegated, such as raising awareness of data protection legislation and chasing services for information to a FoI or SAR. We note that some areas have formally assigned IAO and IAA and a progressed IAR, however, not all areas of the Health Board are engaged, therefore, there is no complete record of what information the organisation holds, if it's correct and up to date, who it's shared with and how it's processed, which not only adds additional pressure on the IG team but is also non-compliant with UK GDPR requirements. This poses a risk of ICO scrutiny and potential formal enforcement notices as detailed under objective 1. Consequently, we have concluded **Limited** assurance for this objective.

Objective 3: An appropriate reporting framework is in place.

2.31 The IG team sits within the Digital Transformation Directorate, and in-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board's Delivery and Performance Committee (DPC) oversees and seeks assurance that information management and governance are sufficient, effective, and robust. In addition, the Health Board has established a Digital Governance Board (DGB), to ensure the effective, efficient, lawful and safe use of information and technologies, including services provided by Powys County Council under the section 33 agreement.

2.32 As noted under objective 1, we observed that the IG Annual Report and regular reporting of IG performance and RMIP updates are received by the DPC, which is inclusive of appropriate Executive-level members, Directors, and several Independent Members. However, from our review of IG team meeting minutes from March 2023, we noted that the business cycle of the DPC was to be modified and IG and RMIP reports are no longer to be submitted quarterly, but instead bi-annually. We understand from the HoIGR that the change has now been agreed. As the Health Board's IG compliance rates are below ICO thresholds and targets as evidenced under objective 1, we would expect to see quarterly reporting as a minimum considering the potential heavy penalties that could be imposed for failing to adequately undertake IG duties. **See Matter Arising 4 at Appendix A**.

2.33 We established that the local IG team have regular meetings with an ongoing action log. IG policies and procedures are reviewed and ratified at the DGB, and operational IG issues (including records management) are raised directly at operational service led meetings.

2.34 IG risks reside on the Digital Transformation Risk Register, which feeds into the Directorate Risk Register (Finance and IT) on an escalation basis and is overseen by the Risk and Assurance Group (RAG). We noted that the risks pertaining to IG are not included on the Directorate Risk Register, despite the residual scores being high, and further observed that RAG have not met since August 2022. As the risk governance structure is non-compliant with its own procedures, this leads to IG risks not being effectively overseen.

2.35 We have previously raised a matter arising around the operation of the RAG as part of our 2022/23 audit of Risk Management (PTHB-2223-01) and a management action to address the issue was agreed with the Director of Corporate Governance.

Conclusion:

2.36 Whilst we observed regular reporting of IG performance to appropriate committees, we have noted the risk of reducing the IG reporting cycle to the DPC to bi-annually. Less frequent formal disclosure could result in less transparency and, in effect, data going unreported for a longer period of time, which in the Health Board's current position of non-compliance with legislative requirements, could hinder the Executive Team in making informed decisions to avoid potential enforcement notices and financial penalties for failing to meet ICO thresholds and targets. Consequently, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Information Governance Team Resources (Design)	**Impact**
Our review highlighted substantial demand on the IG function. The sustained high number and growing trend of more complex statutory requests and requirements has created a reactive rather than proactive way of working. There is a mounting challenge to adequately manage legislative responsibilities across areas such as FoI and SARs, as evidenced by below-threshold compliance rates, as well as maintain progress with non-core functions and meet strategic requirements to develop IG arrangements. KPI reporting is against the number of requests received without measurement against the level of resources available to handle them. This does not provide an adequate representation of the IG team's current or future capacity, as there is no detail of the time and resources required to resolve requests.	Potential risk of: • non-compliance with legislation

	Recommendations	**Priority**
1.1	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	**High**
1.2	As part of the recommended assessment, the Health Board should consider re-assigning managerial responsibility of junior staff to the Senior Officer and Managers within the IG team to allow the HoIGR to invest time in their role as DPO, ensuring that any amendments are updated in respective job descriptions.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

1.1	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.	30/5/2024	**Head of Information Governance, Records and DPO**
1.2	Accept: Job Descriptions of both the Documents and Records Manager and Information Governance Manager have been updated to include managerial responsibility and these have been through Consistency Panel. Request has been made through ESR to reflect these changes and delegate managerial responsibility.	COMPLETE	**Head of Information Governance, Records and DPO**

Matter Arising 2: IG Structure (Design)	**Impact**
Information Asset Owners (IAO) and Information Asset Administrators (IAA) have been assigned in some but not all areas of the Health Board. Information Asset Owners should be responsible for ensuring that all information held by their directorate/service area is used and managed effectively, efficiently, securely, responsibly, and legally, regardless of format. To do this, IAO responsibility needs to be formally assigned in all areas. Whilst the Health Board has key defined roles and mechanisms of engaging its employees with IG through policies, guidance, training and IG alerts for example, we identified that it does not have service-level IG Leads / Champions as observed in other NHS Wales organisations. IG Leads / Champions support the IG function by channelling information on data protection within their respective areas and ensure tasks are completed for the IG team. We understand from the HoIGR that due to the unique way the Health Board is structured that identifying staff who are operational, and the correct level of seniority to be IG Leads / Champions has proved difficult in the past, however, this should be revisited in conjunction with identifying appropriate IAO and IAA, with the purpose of assisting the IG team in discharging its duties.	Potential risk of: • non-compliance with legislation

Recommendations		**Priority**
2.1	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.	**High**
2.2	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.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

2.1	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.	**28/2/24**	**Head of Information Governance, Records and DPO**
2.2	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.	**31/3/24**	**Head of Information Governance, Records and DPO**

Matter Arising 3: Information Asset Register (IAR) (Design)	**Impact**
The Health Board has been unable to review and progress the content of the IAR since its development in 2018/19. It is imperative that organisations know what information they hold, if it's correct and up to date, who it's shared with and how it's processed. An IAR should be developed as a tool to track this information and not only show what information is held where, but to also map out the information flows to ensure there are appropriate security measures and controls in place based on how information moves around. Linked to matter arising 2, the IAO and IAA should be responsible for progressing the IAR within their respective areas.	Potential risk of: • non-compliance with legislation

Recommendations			Priority
3.1	The Health Board should ensure that the IAR is progressed by the Information Asset Owners and Information Asset Administrators identified under recommendation 2.1.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	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.	**31/3/24**	**Head of Information Governance, Records and DPO**

Matter Arising 4: IG Reporting Arrangements (Operation)			**Impact**
We note that the business cycle of the Delivery and Performance Committee has been modified and IG performance reports are no longer to be submitted quarterly, but instead bi-annually. As the Health Board's IG compliance rates are below ICO thresholds and targets, we would expect to see quarterly reporting as a minimum considering the potential heavy penalties that could be imposed for failing to adequately undertake IG duties.			Potential risk of: • non-compliance with legislation.
Recommendations			**Priority**
4.1	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.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	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.	**1/3/24**	**Director of Corporate Governance**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.3

Audit, Risk and Assurance Committee	**Date of Meeting: 16 January 2024**
Subject:	**Internal Audit Themes and Reflections**
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 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.

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Consider** the themes and reflections highlighted through the analysis of the outcomes of previous Internal Audit work.

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 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 date). Along with some comparison to the work completed for all NHS organisations within Wales.

This includes details of the assurance ratings provided for all the audits completed over the period, the recommendations made as part of the audits and the themes of the recommendations.

The presentation is intended to highlight the key issues and themes identified through the previous Internal Audit work, in order to inform thinking around potential areas of future focus for both the Committee and Internal Audit.

BACKGROUND AND ASSESSMENT:

The Audit & Assurance Business Manager undertook a project in 2022 to review and collate data from the previous 4 years of completed internal audits for all 13 organisations within NHS Wales.

This led to the creation of an Audit & Assurance Review database, and the outcomes of all audits have since been added to the database as they are completed.

The collected data is all publicly available, within published reviews from NWSSP Audit and Assurance teams or within the Head of Internal Audit Annual Opinions.

A Power Bi report has also been created to analyse the information within the database in order to highlight any trends, risks, and to support with planning internally for the Audit and Assurance teams within NWSSP. It also provides the opportunity for Heads of Internal Audit and client organisations to investigate where recommendations, risks or issues are consistently arising within each organisation or NHS Wales in totality.

The 'Internal Audit themes and reflections' presentation has been created from the database utilising the Power BI report, and provides information on the Powys Internal Audit work completed over the last 6 years.

The following is a brief summary of the information provided within each slide. Further analyses and explaination will be provided as part of the presentation:

Slide 1 – Introduction slide.

Slide 2 - Gives an overall view of the total volume of Internal Audit work completed for Powys over the last 6 years. It identifies the numbers of audits completed each year and the outcomes across the 5 assurance ratings per year, and as an overall percentage.

Slide 3 - Gives the same overall view for all NHS Wales organisations.

Slide 4 - The Internal Audit plan is structured around 8 domains. This slide analyses the assurance ratings provided for the audits completed within each of the domains over the full 6 year period.

Slide 5 - Gives the same information around domains but looking only at 21/22, 22/23 and 23/24 to date. This should remove the main effect of the Covid year and any older issues.

Slide 6 - Gives same Domain info for the three recent years but for all NHS Wales organisations.

Slide 7 - Gives details of the recommendations we have made as part of all the audits completed over the 6 years. This analyses the recommendation's priority ratings, whether they are design or operational in nature and the key 'themes' that they are linked to.

Slide 8 - Gives the same information around recommendations, ratings and themes but again looking only at 21/22, 22/23 and 23/24 to date.

Slide 9 - Confirms what the narrative is for the 5 most common themes.

Slide 10 – Gives the same recommendation & theme info for the recent years for all NHS Wales organisations.

Slide 11 – Looks at the recommendations and themes over the last 3 years within the Capital and Estates Domain, as this is one of the domains with more Limited assurance audits.

Slide 12 – Looks at the same for the Information Governance and Security Domain, another with more Limited assurance audits.

NEXT STEPS:

Further analysis of the Audit & Assurance review database can be provided to the Committee if required, either on an ad-hoc or regular periodic basis.

Microsoft | Power BI

Internal Audit Themes and Reflections

Audit & Assurance Review Database

View in Power BI

Last data refresh:
11/12/2023 10:16:13 UTC

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14/12/2023 07:51:41 UTC

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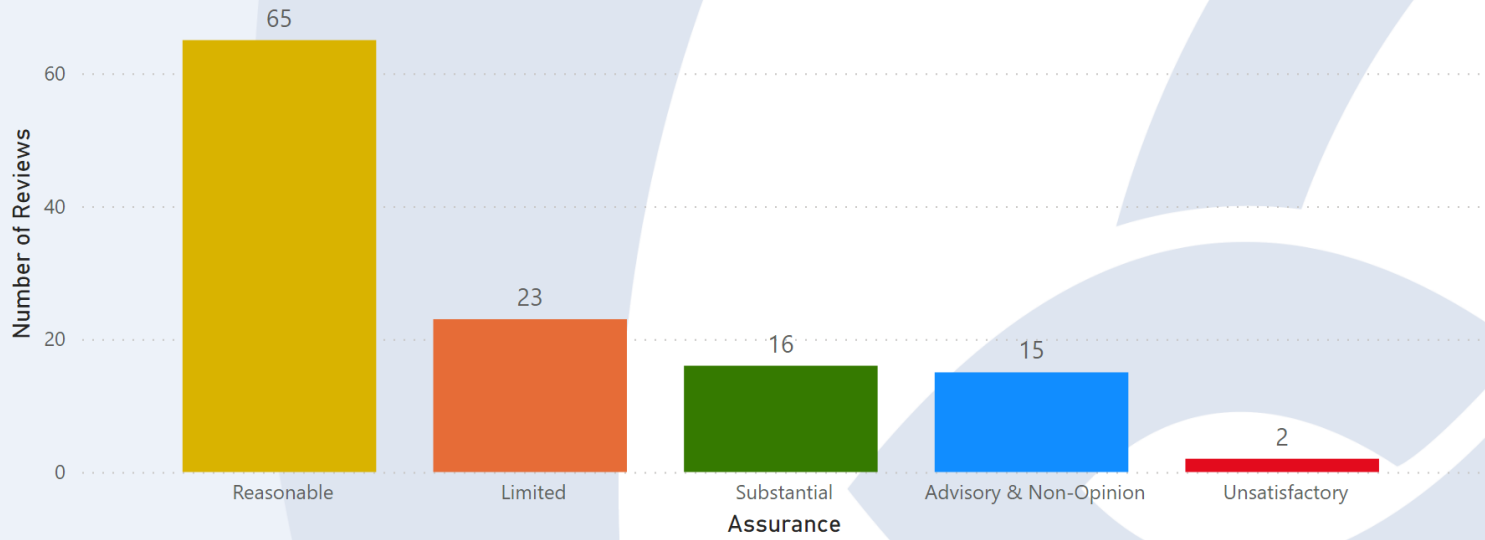
2018 - 2023 Assurance Ratings Provided



Year	Number of Reviews Completed
2018/19	26
2019/20	27
2020/21	19
2021/22	19
2022/23	23
2023/24	7
Total	**121**

* 2023/24 review information includes daft reports.

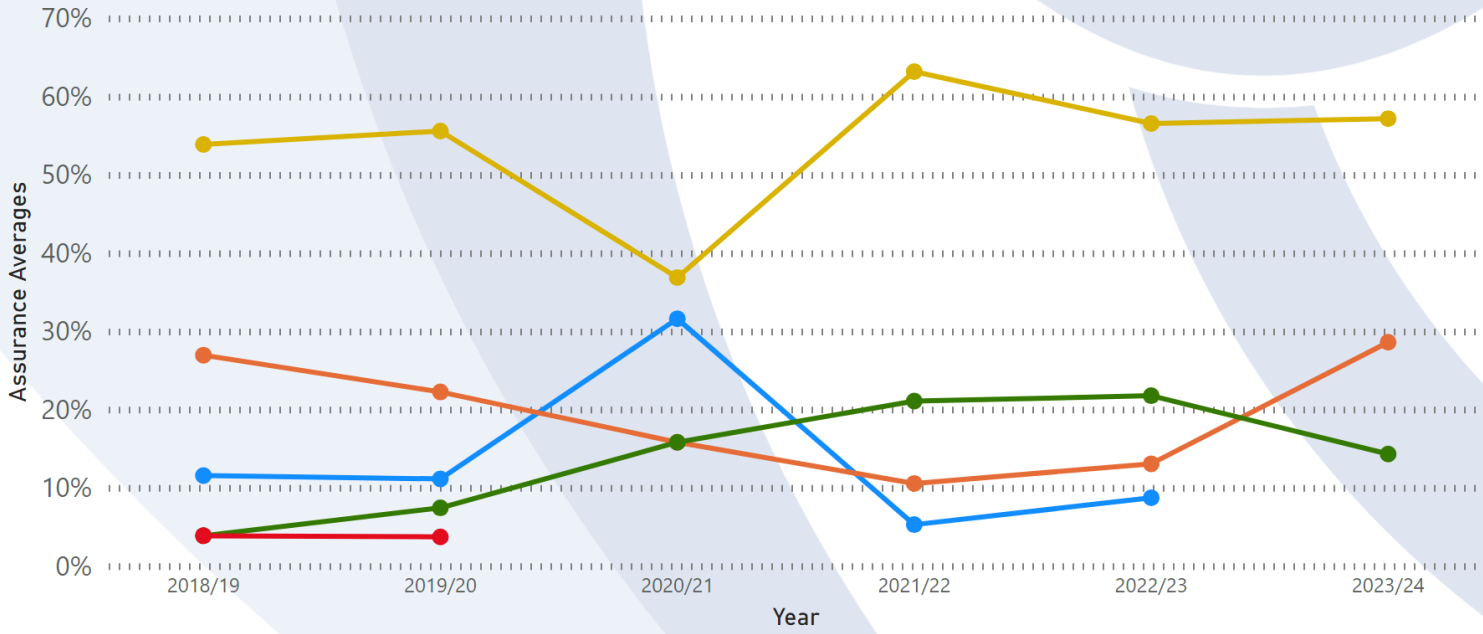
Organisation

- [ ] Select all
- [ ] Aneurin Bevan
- [ ] Betsi Cadwaladr
- [ ] Cardiff & Vale
- [ ] Cwm Taf Morgannwg
- [ ] DHCW
- [ ] HEIW
- [ ] Hywel Dda
- [ ] NWSSP
- [ ] PHW
- [x] Powys THB
- [ ] Swansea Bay
- [ ] Velindre
- [ ] WAST

Willis Belinda 15/01/2024 09:45:47

Assurance Reasonable Limited Substantial Advisory & Non-Opinion Unsatisfactory

2018 - 2023 Assurance Trend



Assurance	2018-23 Assurance (%)
Advisory & Non-Opinion	12.4%
Limited	19.0%
Reasonable	53.7%
Substantial	13.2%
Unsatisfactory	1.7%

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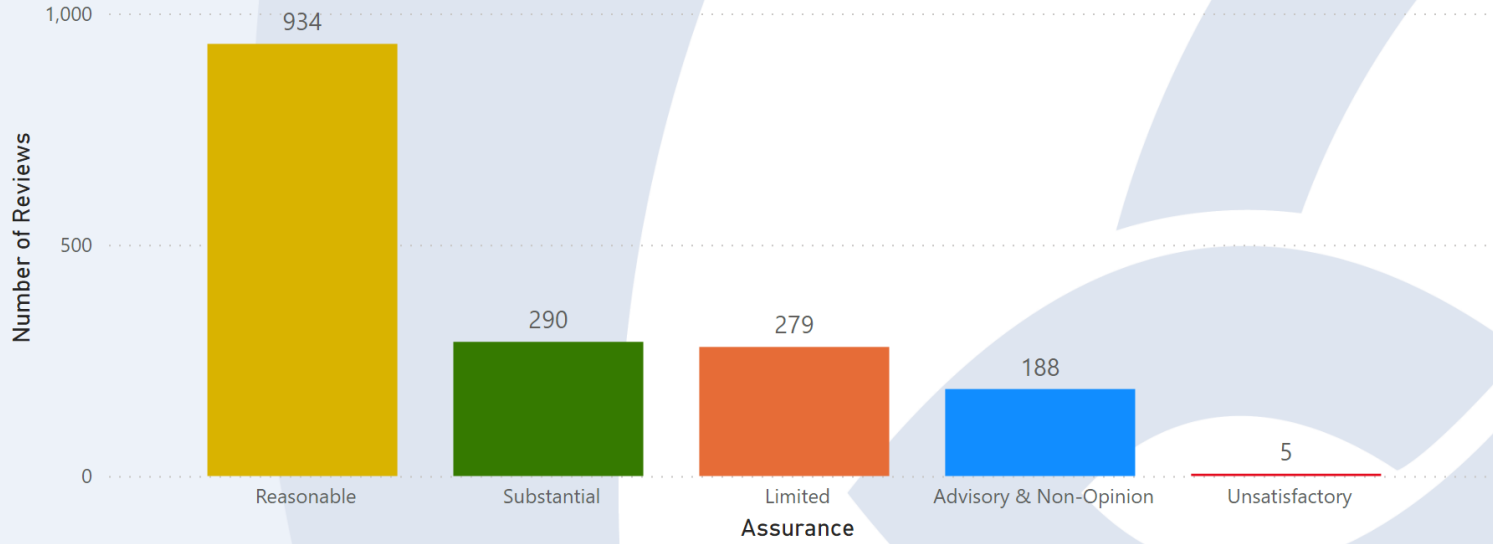
2018 - 2023 Assurance Ratings Provided



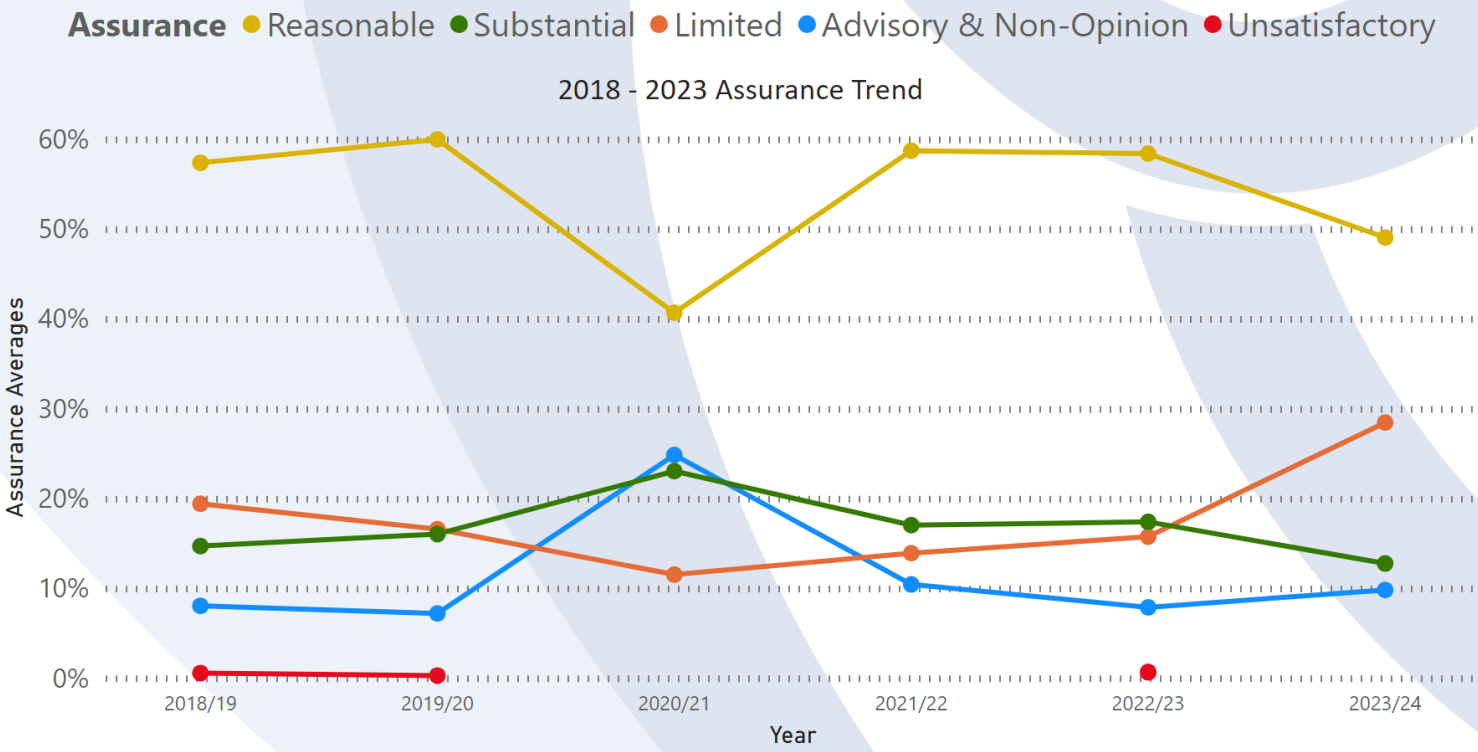
Year	Number of Reviews Completed
2018/19	361
2019/20	362
2020/21	278
2021/22	288
2022/23	305
2023/24	102
Total	**1696**

* 2023/24 review information includes daft reports.

Organisation

- Select all
- Aneurin Bevan
- Betsi Cadwaladr
- Cardiff & Vale
- Cwm Taf Morgannwg
- DHCW
- HEIW
- Hywel Dda
- NWSSP
- PHW
- Powys THB
- Swansea Bay
- Velindre
- WAST

Willis, Belinda
15/01/2024 09:45:47



Assurance	2018-23 Assurance (%)
Advisory & Non-Opinion	11.1%
Limited	16.5%
Reasonable	55.1%
Substantial	17.1%
Unsatisfactory	0.3%

2018-23 Domain Assurance Overview

Domain	Number of Reviews
Workforce Management	14
Strategic Planning, Performance Management and Reporting	12
Operational Service and Functional Management	19
Information Governance and Security	14
Financial Governance and Management	9
Corporate Governance, Risk and Regulatory Compliance	14
Clinical Governance, Quality and Safety	18
Capital and Estates	21
Total	**121**

Organisation

Powys THB

Year

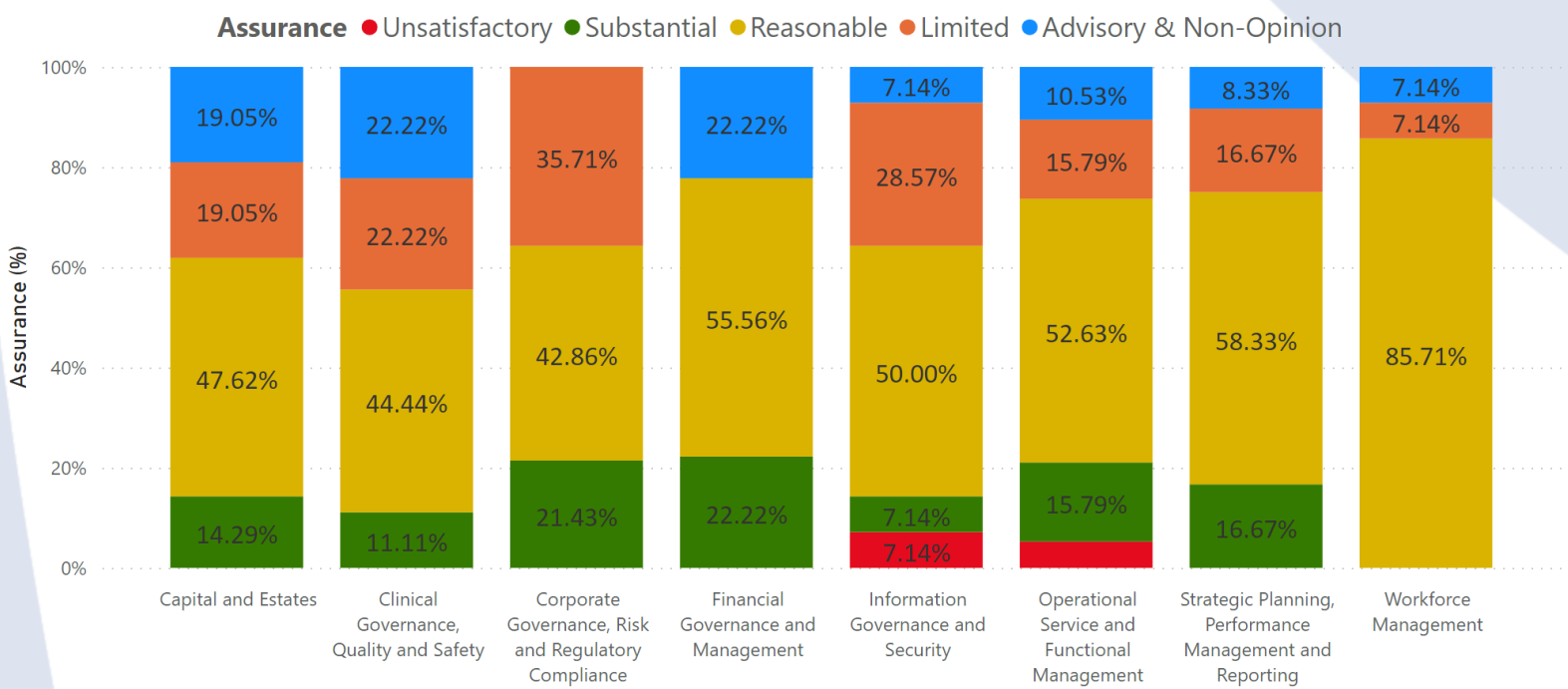
All

121

Total Number of Reviews

Show Domain Assurance Trend

Assurance Breakdown by Domain



2018-23 Domain Assurance Overview

Domain	Number of Reviews
Workforce Management	7
Strategic Planning, Performance Management and Reporting	4
Operational Service and Functional Management	10
Information Governance and Security	5
Financial Governance and Management	3
Corporate Governance, Risk and Regulatory Compliance	6
Clinical Governance, Quality and Safety	6
Capital and Estates	8
Total	**49**

Organisation

Powys THB

Year

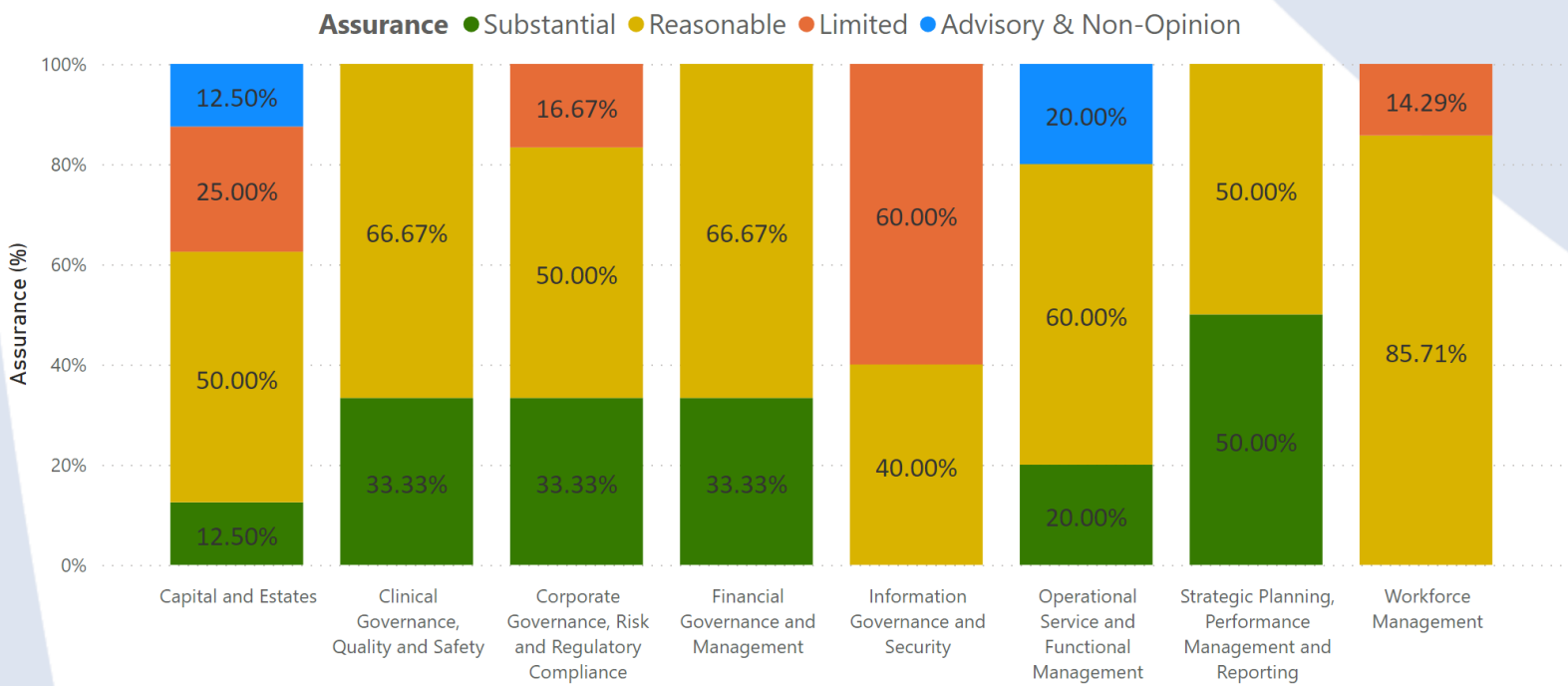
Multiple selections

49

Total Number of Reviews

Show Domain Assurance Trend

Assurance Breakdown by Domain



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2018-23 Domain Assurance Overview

Domain	Number of Reviews
Workforce Management	73
Strategic Planning, Performance Management and Reporting	47
Operational Service and Functional Management	98
Information Governance and Security	94
Financial Governance and Management	75
Corporate Governance, Risk and Regulatory Compliance	91
Clinical Governance, Quality and Safety	90
Capital and Estates	117
Total	**685**

Organisation

All

Year

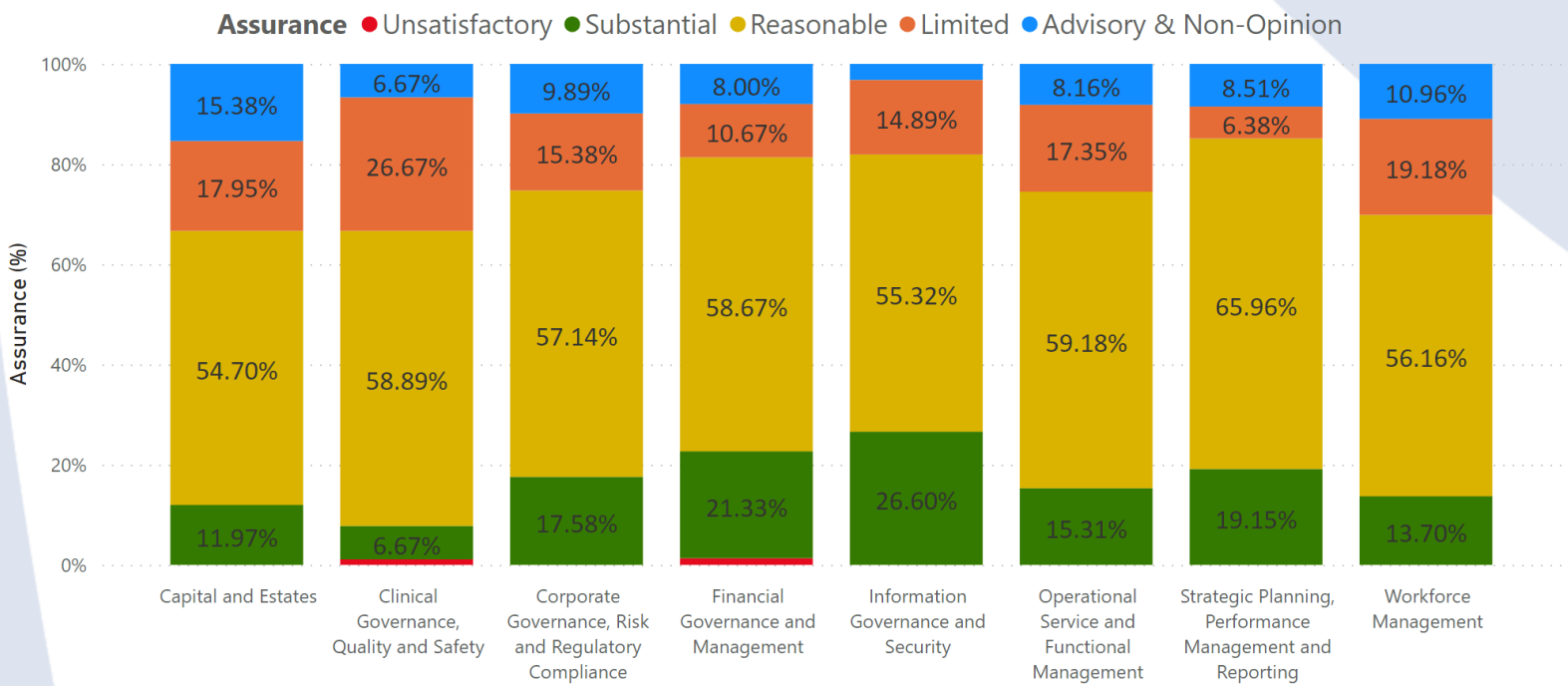
Multiple selections

685

Total Number of Reviews

Show Domain Assurance Trend

Assurance Breakdown by Domain



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106	462	4.36
Number of Reviews (exc. Advisory)	Total Recommendations	Average Recommendations (ex...

Organisation: Powys THB

Year: All

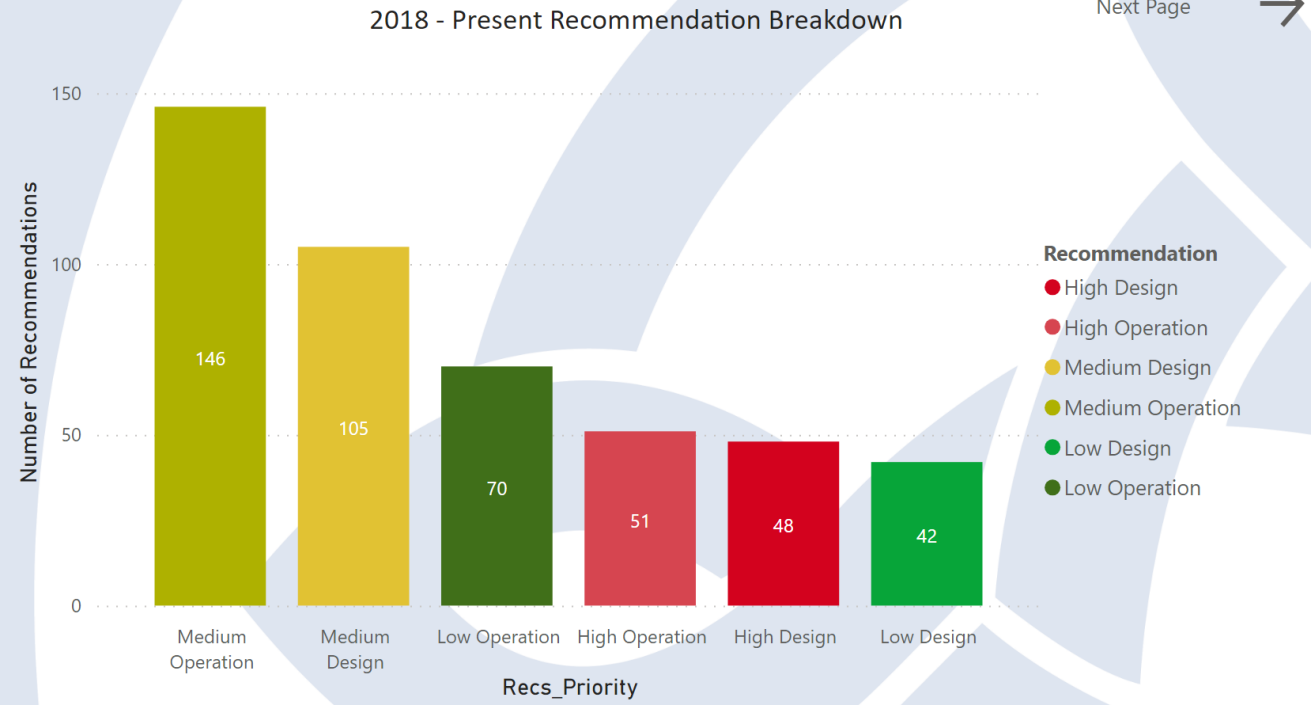
Domain: All

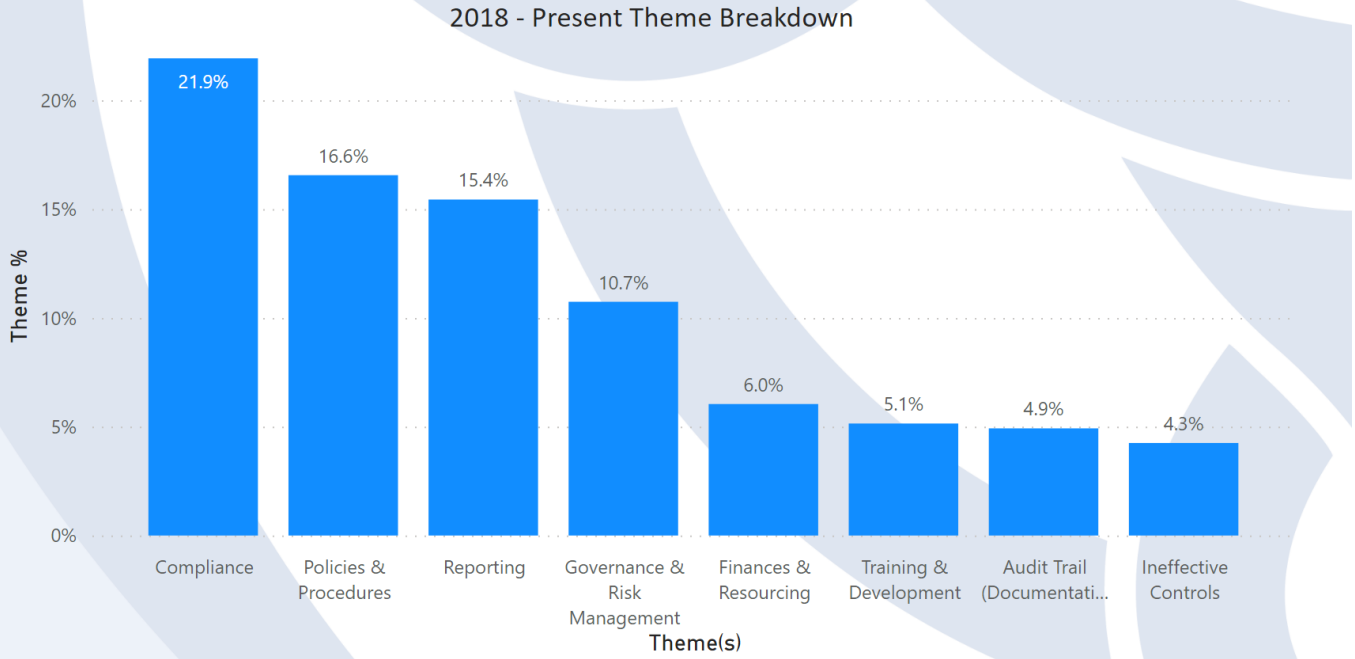
Audit Title: All

Most Identified Theme(s)

8

Theme(s)	Number of Times Identified
Compliance	98
Policies & Procedures	74
Reporting	69
Governance & Risk Management	48
Finances & Resourcing	27
Training & Development	23
Audit Trail (Documentation)	22
Ineffective Controls	19





46	197	4.28
Number of Reviews (exc. Advisory)	Total Recommendations	Average Recommendations (ex...

Organisation: Powys THB

Year: Multiple selections

Domain: All

Audit Title: All

Most Identified Theme(s)

8

Theme(s)	Number of Times Identified
Compliance	46
Reporting	29
Policies & Procedures	22
Governance & Risk Management	15
Audit Trail (Documentation)	12
Ineffective Controls	10
Finances & Resourcing	8
Training & Development	7

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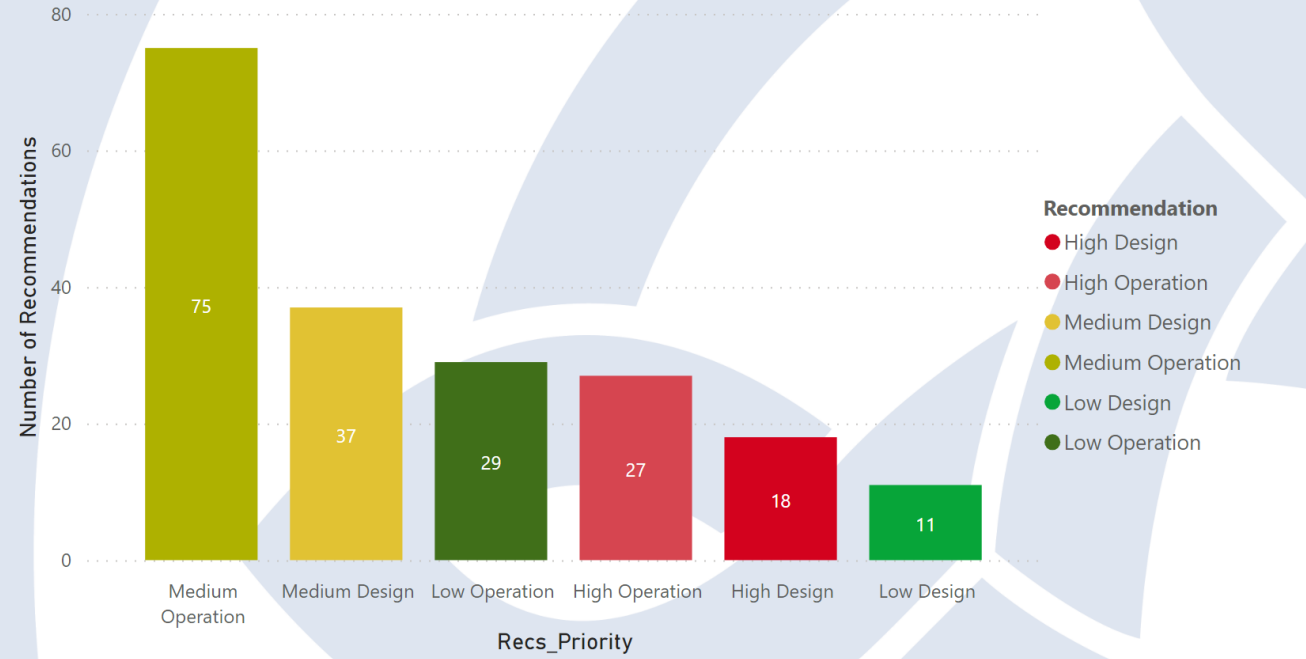
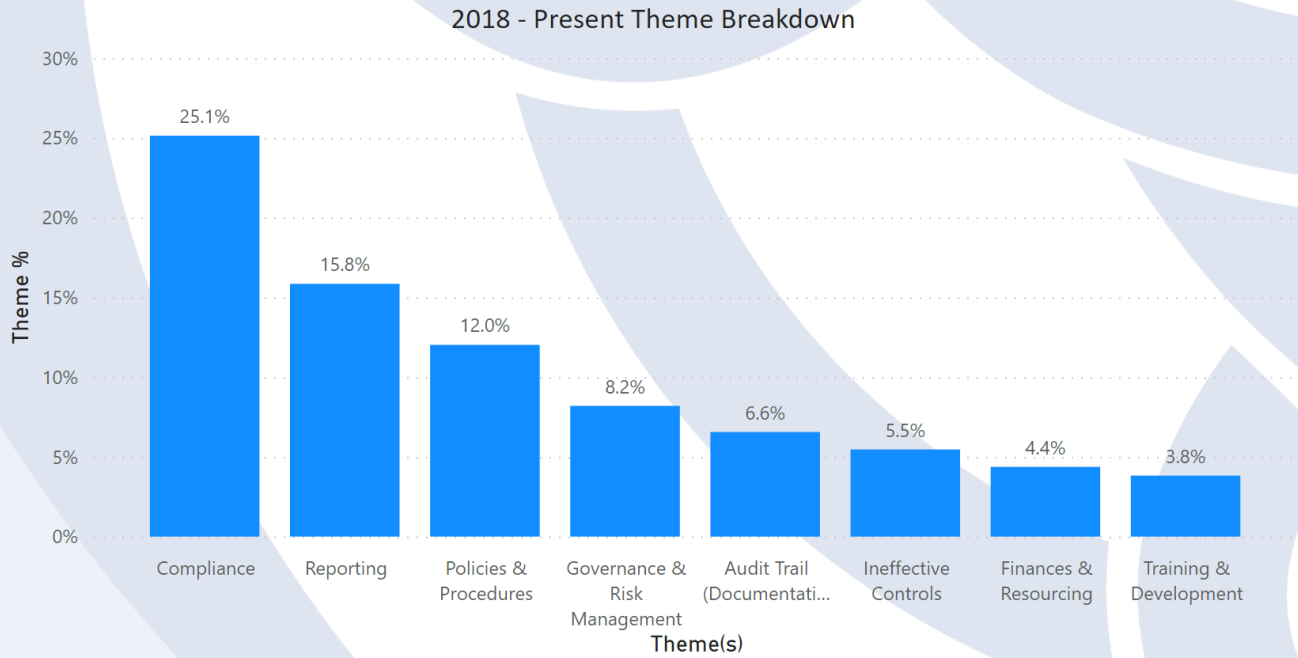




Theme Descriptions

Compliance

Non-compliant with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation.

Reporting

The adequacy, quality or accuracy of reporting is insufficient for assurance. Or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions.

Policies and Procedures

Inadequate or lack of policies and procedures in place.

Governance & Risk Management

Formal governance routes are inadequate, ineffective, or there is a lack of understanding of them. This may affect the ability to identify, assess and manage risk.

Audit Trail Documentation

There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail.

631	2504	3.97
Number of Reviews (exc. Advisory)	Total Recommendations	Average Recommendations (ex...

Organisation: All

Year: Multiple selections

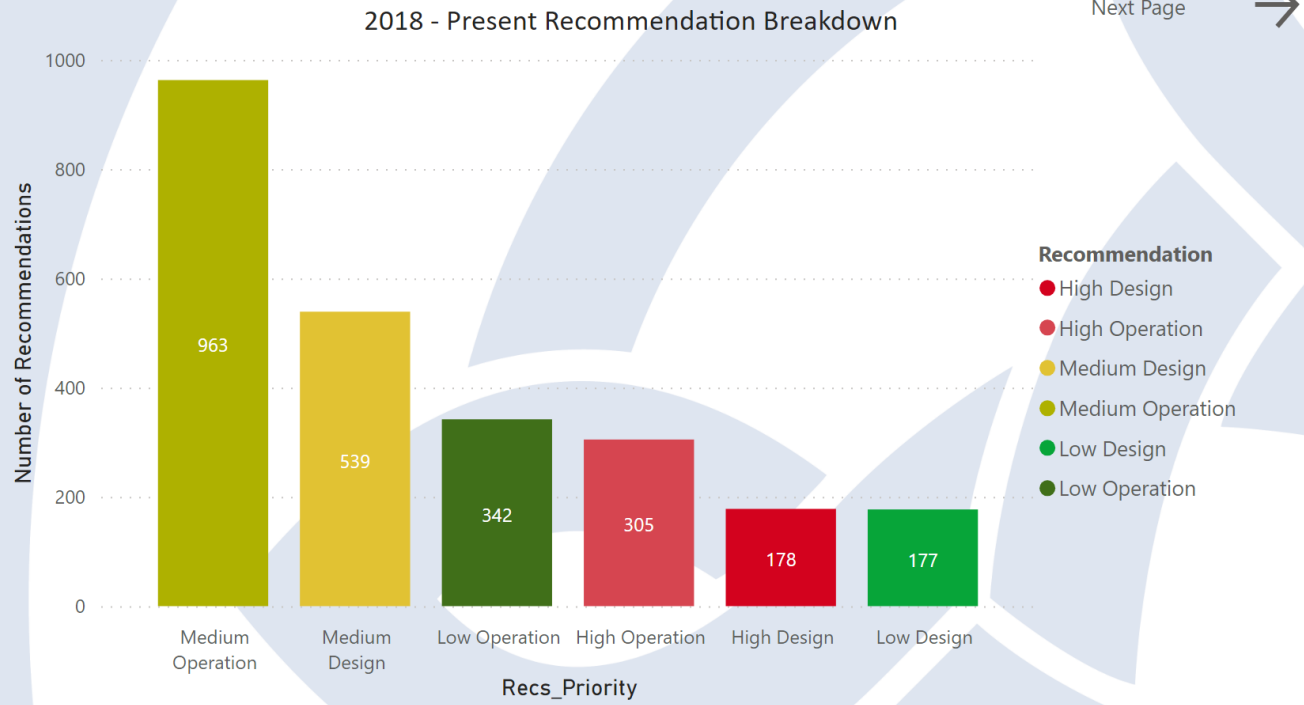
Domain: All

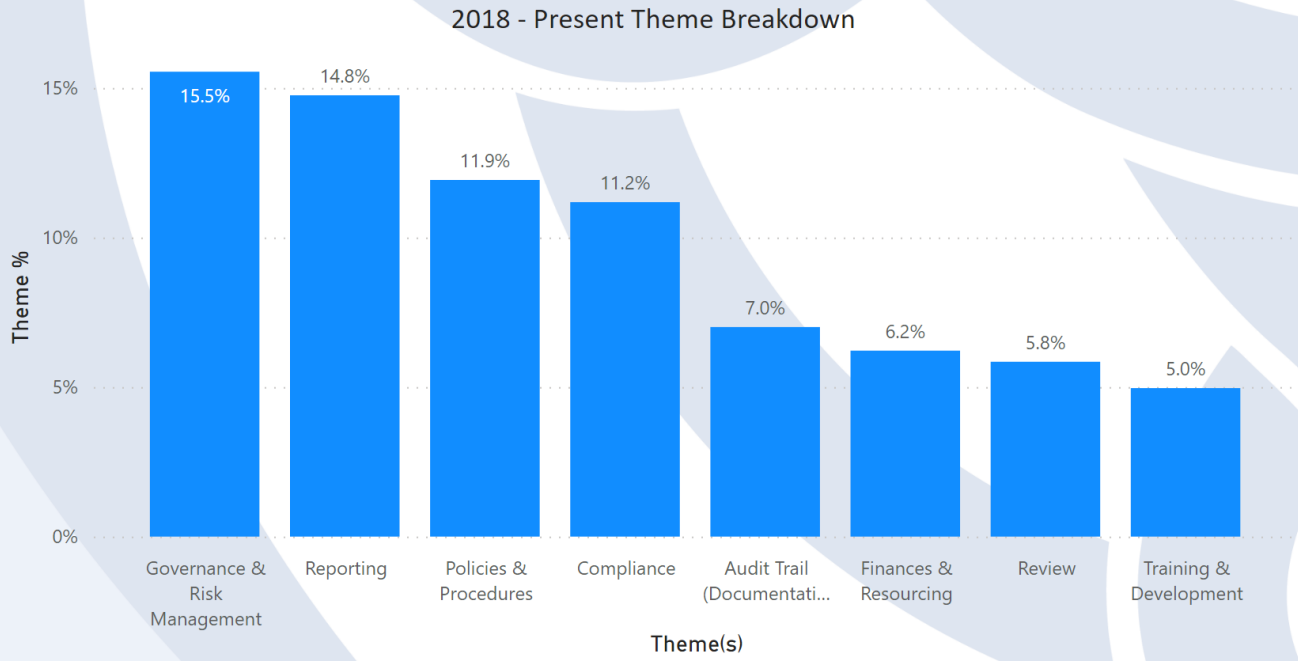
Audit Title: All

Most Identified Theme(s)

8

Theme(s)	Number of Times Identified
Governance & Risk Management	335
Reporting	318
Policies & Procedures	257
Compliance	241
Audit Trail (Documentation)	151
Finances & Resourcing	134
Review	126
Training & Development	107





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7	40	5.71
Number of Reviews (exc. Advisory)	Total Recommendations	Average Recommendations (ex...

Organisation: Powys THB

Year: Multiple selections

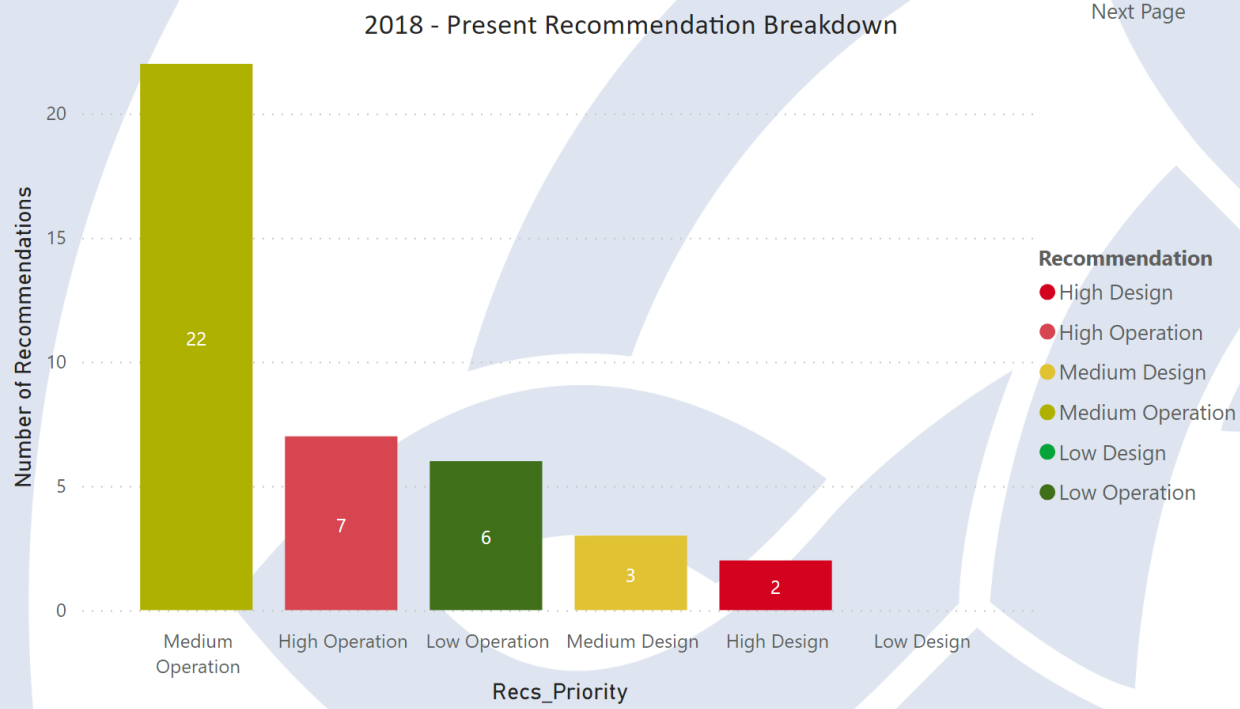
Domain: Capital and Estates

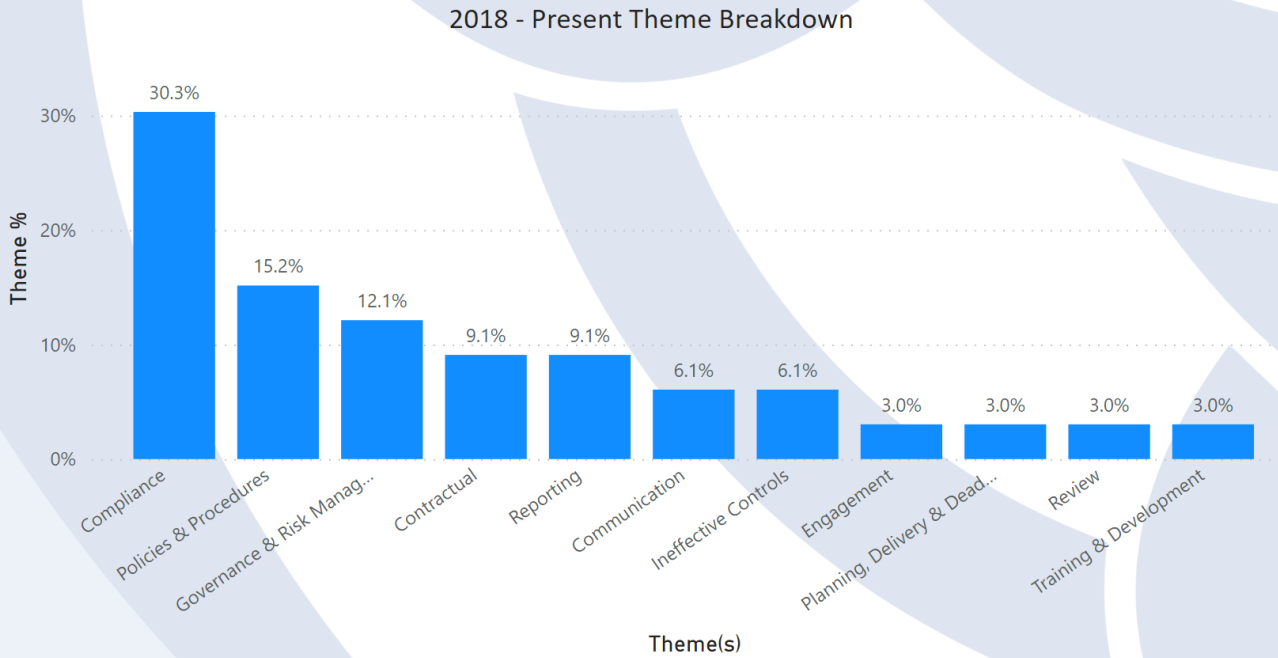
Audit Title: All

Most Identified Theme(s)

8

Theme(s)	Number of Times Identified
Compliance	10
Policies & Procedures	5
Governance & Risk Management	4
Contractual	3
Reporting	3
Communication	2
Ineffective Controls	2
Engagement	1
Planning, Delivery & Deadline Management	1





5	21	4.20
Number of Reviews (exc. Advisory)	Total Recommendations	Average Recommendations (ex...

Organisation: Powys THB

Year: Multiple selections

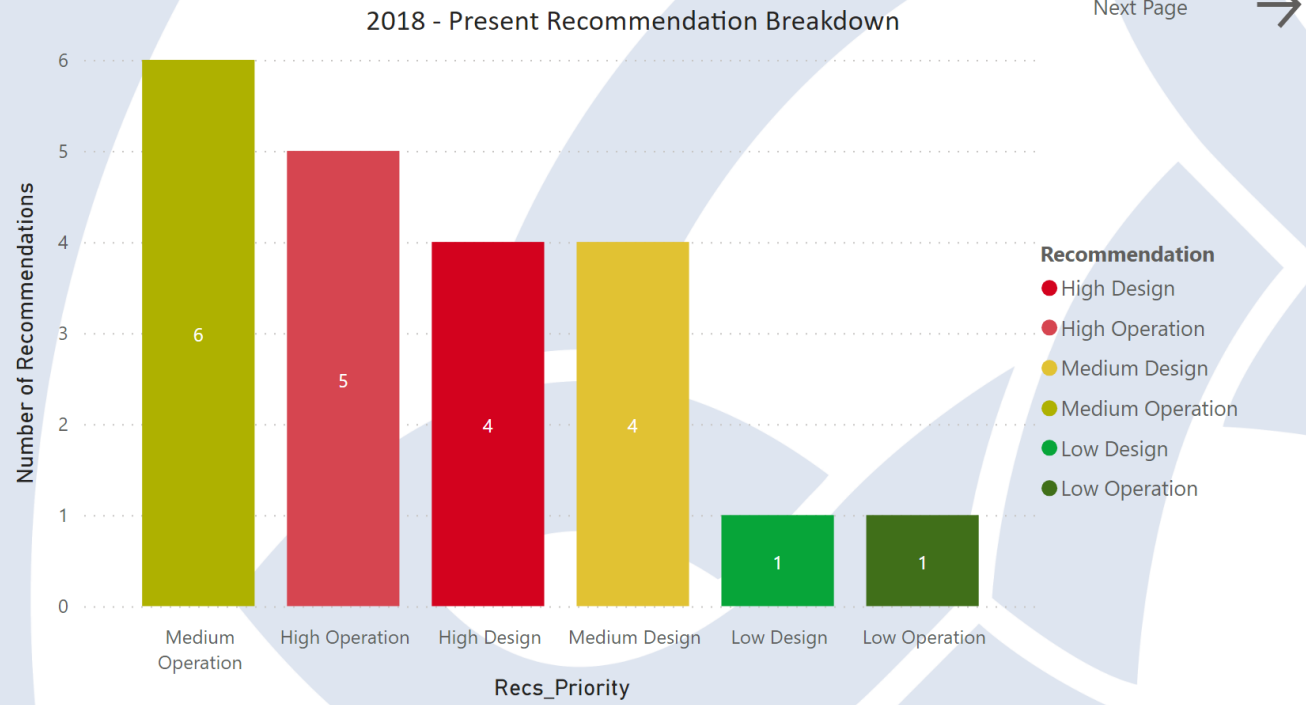
Domain: Information Governance and S...

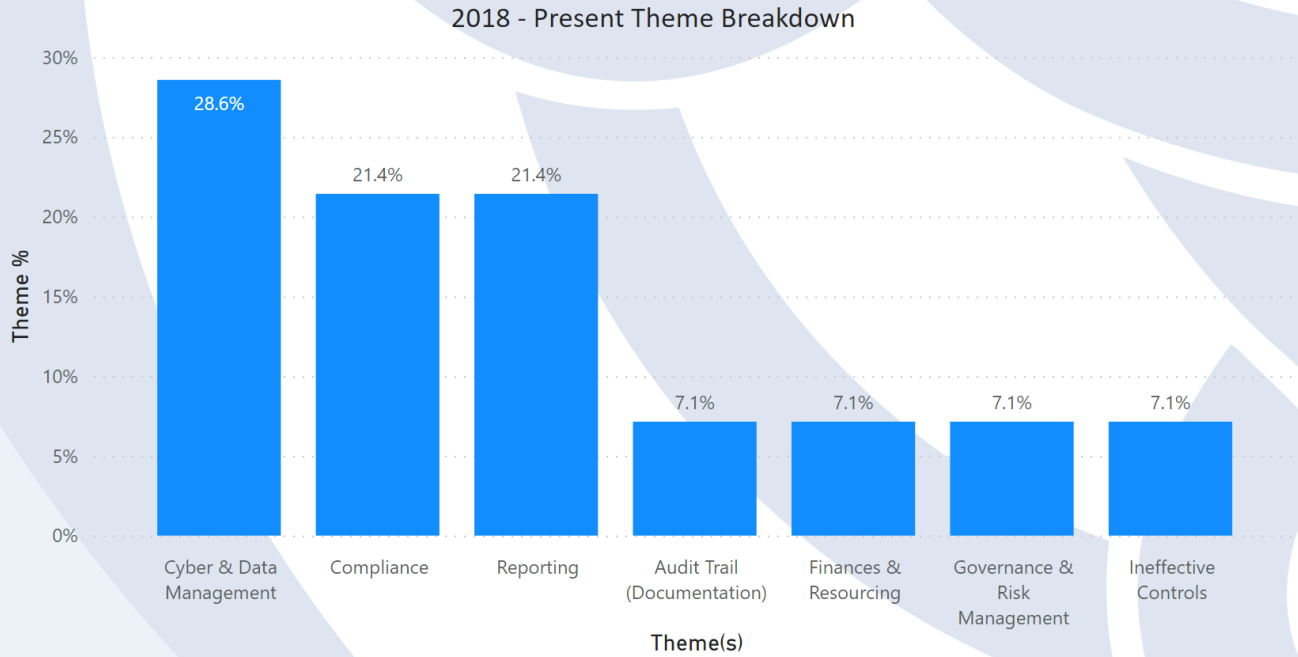
Audit Title: All

Most Identified Theme(s)

8

Theme(s)	Number of Times Identified
Cyber & Data Management	4
Compliance	3
Reporting	3
Audit Trail (Documentation)	1
Finances & Resourcing	1
Governance & Risk Management	1
Ineffective Controls	1
Communication	0
Compliance, Governance & Risk Management	0





Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.4

Audit, Risk & Assurance Committee	**DATE OF MEETING: 16 January 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:	Audit, Risk and Assurance Committee 16 January 2024

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 30 November 2023.

RECOMMENDATION(S):

The Committee is asked to:

- **CONSIDER** the current position of outstanding Audit Recommendations, and
- take **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

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

BACKGROUND AND ASSESSMENT:

INTERNAL AUDIT

During quarter three of 2023/24, an exercise was undertaken to review the revised deadlines implemented as a result of the COVID-19 priority level. Executive Owners were provided an opportunity to review any outstanding recommendations from 2017/18, and 2019/20 and re-consider where appropriate, achievable final deadlines for implementation that could be monitored against. The revised deadlines are included within the appendices. All recommendations from 2018/19 are now complete.

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

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

Covid-19 Prioritisation	2019/20	Internal Audit Priority	2020/21	2021/22	2022/23	2023/24	TOTAL OUTSTANDING
	Number		Number				Number
Priority 1	0	High	1	5	7	1	14
Priority 2	4	Medium	2	8	14	2	30
Priority 3	3	Low	1	1	7	1	13
Not Yet Prioritised	0						0

TOTAL	**7**		**4**	**14**	**28**	**4**	**57**

Detail of re-prioritised 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.

Work continues to ensure that audit recommendations are closely monitored and completed, since this report was produced a further 7 recommendations have been completed for closure from 2019/20 and 2020/21, these and any additional closures will be produced to the Committee for its March meeting.

EXTERNAL AUDIT

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

Overdue External Audit Recommendations						
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**TOTAL OUTSTANDING**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Priority 1	0	0	0	0	0	0
Priority 2	1	0	1	0	0	2
Priority 3	0	0	0	0	0	0
Not Yet Prioritised	0	0	0	1	5	6
TOTAL	**1**	**0**	**1**	**1**	**5**	**8**

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

Appendix 4 – External Audit Recommendations that remain OUTSTANDING.
Appendix 5 - External Audit Recommendations Not Yet Due for Implementation (NB. None in this category)
Appendix 6 – 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 Corporate Governance Team and report4d to the Executive Committee and Audit, Risk and Assurance Committee.

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 being made to implement recommendation				If action is complete, can evidence be	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
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 recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. 06/04/23 - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	Sep-21		27	18	Mar-23	
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.	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.	Mar-20	Apr-21	Overdue	2	Partially complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 As part of the restructure of the team in CSG betweeen November 2021and January 2022 the service was re mapped against activity and new pathways and a revised service model was implemented. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. 02.02.2023 - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. 06/04/23 - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group	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		26	14	May-23	Sep-20
192023	Estates Assurance Follow Up	Reasonable	Associate Director of Capital and Estates	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		Jan-21	Oct-22	Overdue	3	Partially complete		Policy now updated and approved with Asbestos Management Plan to be agreed in Asbestos Management Group. Last element related to 'labelling' now agreed and finalisation of document and approval at next meeting only now outstanding	Procedural elements have needed to be agreed collectively by Asbestos Safety Group which meets bi-monthly	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and introduce site specific management plans.	Aug-23		28	6	May-23	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 Jan 2024, reports will be provided as the year progresses.	COVID-19	Agendas for all meetings continue to be scrutinised in order to ensure that the Board is receiving appropriate assurance.	Jan-24		12	2	May-23	Sep-20
192027	Welsh Language Standards Implementation	Limited	Director of Workforce and OD	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: 1. the roll of out awareness sessions, keeping records of attendance; 2. increasing the frequency and content of internal communications; and; 3. the Standards included as a standing agenda item at Directorate and service level meetings to ensure progress against action plans is monitored. 4. Consideration should be given to developing a communications strategy to ensure staff are familiar with the Standards, understand its impact on their roles and the support and resources available to them to comply.	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to record staff training. Opportunities to deliver this training session virtually will be explored in order to reach as many staff as possible across the health board. In addition, the health board will look to increase opportunities to raise awareness of the Standards to all staff across the organisations via a range of communication methods. The health board will continue to liaise with the Assistant Director of Communications to develop and promote a new Communications Guide for staff across the health board which includes guidance on complying with the requirements of the Welsh Language Standards and will offer examples of best practice. A communication strategy will form part of the overarching Welsh language action plan as outlined in the response to recommendation 2 above.	Mar-21	Mar-22	Overdue		Partially complete		1. Welsh language awareness sessions are routinely held as part of the corporate induction days on a monthly bssis ensuring that all new staff to PTHB are aware of the Welsh language standards and the support that's available. Awareness sessions are also being held with individual teams across the health board. Data on number of attendees is available. 2. Information on Welsh language standards is routinely sent out to staff via Powys Announcements, emails, social media channels and staff sessions such as the corporate induction. Our new sharepoint pages include comprehensive information on complying with the Welsh language standards as well as information on how to learn Welsh and what support is available. For the launch of our new Sharepoint site all our Welsh language guidance for staff have been updated. 3. NWSSP Audit plan mainly completed with a few outstanding departments yet to return action plans. A decision has been made not to chase this up with departments due to presures. 4. A regular Welsh newsletter reminds staff of the requirements of the Standards 5. As part of a tour of PTHB sites alongside the Wellbeing roadshows, Welsh Language team staff have been visiting sites and advising on indiviudal locations; all main sites have been visited at least once.	Lack of resources to fully implement the WL Standards. Additional funding requirements for translation costs.	Regular monitoring and reporting via the Executive Lead for WL. Additional resource has been allocated for translation costs.	1 - complete 2 - complete 3 -March 2024 audit revisit 4-Complete 5-Complete		26	14	May-23	Sep-20
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 wil take priority.	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		20	14	May-23	

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		Overdue		Partially complete		Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements. Nov 2023- DTOC system now revised to Pathways of Care Monitoring. PTHB has been reporting on a monthly Census since April 2023 and working with the delivery unit through regular action planning. Patient pathways are embedded on admission. National guidelines for discharge have been published, PTHB local discharge guidelines under review- to work with our partners in development with aim of completion by end of January 2024			01/02/2024		14		May-23	
202115	Winter pressures and flow management	Reasonable	Director of Operations	Senior Manager Unscheduled Care	R3	3.1 As part of formalising the PFCU business cycles (see MA1), the health board should consider the key performance metrics for patient flow performance (including delayed transfers of care) to be used for reporting at each level within the health board and how frequently these should be reported. 3.2 The health board could refer to the 2017 Audit Wales report (Discharge Planning, Powys Teaching Health Board) in identifying metrics, recognising some of the metrics in that report are only relevant for acute care.	3.1 KPI's and pathways are in situ but "paused" whilst DTOC reporting was stepped down. When recommenced a review of pathways will be held to ensure they are in line with any revised guidelines. KPI's for delays & repatriation times will be developed once the technology supports this – incoming with electronic flow system. 3.2 The HB will focus on national guidelines for step down & step up beds as a mechanism to support the identification and development of metrics - currently working with Hywel Dda University Health Board & the NHS Wales Delivery Unit to establish a cross agency recording system which will lead to a shared data set. Metrics for discharge pathways is already established.	May-22		Overdue		Partially complete		Still awaiting direction from WG, which is expected November 2021. 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. Will ensure KPI's are in line with national requirements when released. Nov 2023- DTOC monitoring system has now been re instated since April 2023 and renamed Pathways of care monitoring by means of a monthly Census. All Wales Repat policy in development Nationally which when published will align to our local PTHB guidelines. Development work is underway by means of implementing a Digital Solution package for patient flow monitoring, and within an Action Plan. Support provided by the NHS exec team for action planning.			TBC as working with the Digital teams to support implementation of a digital solution for patient flow.		12		May-23	
202115	Winter pressures and flow management	Reasonable	Director of Operations	Senior Manager Unscheduled Care	RS	Given the impact of the Covid-19 pandemic and the ongoing development of patient flow initiatives, the health board should consider undertaking a formal demand and capacity review for staff resource for patient flow.	Seven-day working was stood up during the pandemic where a demand & capacity review was completed for weekend working. As a result, the HB established no demand for seven day working but has a plan to flip if required to seven days. Outside of this flow is managed & workload of CTC's is manageable There is sufficient evidence to support this (i.e. staff within working hours, flow adequate & ability to flex within teams). The HB will consider a demand & capacity review in its longer-term plan.	Jul-22		Overdue		Partially complete		The Health Board has daily oversight via CTC's on the number of patients requiring repatriation back to Powys. Whilst CTC's are not employed 7 days per week the position on a Monday morning is quickly understood. The Health Board will pick up demand and capcity planning as part of 23/24 overall IMTP planning Nov 2023, Implementation of a discharge Liason Officer role to sit within the patient flow team is making progress and by January 2024 should see a total of 4 members of staff. The role aims to support discharge planning ward side wit improvements to lenght of stay, improving the patient's journey.			Jan-24		10		May-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	Medical Device & POCT Manager	R1	1. A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. 2. The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. 3. The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	1. Management will ensure a review of the purpose of the Preferred Equipment List is undertaken. How it is maintained and kept current will be part of this review. Both Procurement and Finance support will be required for this review. 2. There is currently a section within the EDOF stating NWSSP Procurement must be involved. However, management will ensure this is strengthened by adding a specific field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. 3. Management will ensure all EDOF's not fully completed will be returned to the requesting service for completion.	Nov-22		Overdue		Complete		A Teams Channel has been created for for both Medical Devices Team and Procurement to access and update the preferrend equipment list. This work includes any All Wales contracts being added by Procurement. Medical Devices Team have reviewed items and categories listed. The list will be presented to the MD&POCT Group in March 2023 for comments to ensure it continues to be efficient and user friendly. 2 & 3. Constant monitoring of EDOF requests by Medical Devices team to ensure Procurement are engaged where applicable and that forms are completed fully. This whole item will be closed by May 2023.	Resource within Medical Devices Team.	Regular meetings and monitoring with Procurement. EDOF process monitors equipment being requested.	This will remain an ongoing action as the preferred equipment list requires constant monitoring and updating in conjunction with Procurement.		6		May-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	Governance Leads	R3	All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service governance leads in the form of self-audits. Governance leads will provide assurance to the Medical Devices Group through "At a Glance Reports."	Nov-21	Feb-22	Overdue		Complete		Examples of evidence received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document to be presented to MD&POCT Group in March 2023 for approval across all services. Full implementation can then take place.	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.	Examples of evidence received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document has been drafted and to be to be shared with MD&POCT Group for approval across all services. Full implementation can then take place. Audit, undertaken locally, will be required to monitor compliance. These will need to be service led as there is no capacity within the Medical Devices Team to undertake these. Assurance from services will be via Highlight reports into MD&POCT Group. This should be completed by the end of May 2023.		18	15	May-23	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Science	Head of Clinical Education / Medical Device & POCT Manager	RS	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.	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.	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	
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.	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	
212204	Midwifery – Safeguarding observation	Reasonable	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding supervision / Assistant Director for Women and Children's services	R1	1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives 1c. Requirements to attend Safeguarding supervision and available dates for Q3 are highlighted through the Midwifery Weekly brief that is shared to all Powys Midwives 2a. Safeguarding supervision compliance will be monitored through monthly Midwifery Management and Leadership Governance meeting and has been included into the Women and Children's Senior Leadership Performance Dashboard 2b. Women and Children's Safeguarding Work plan to be reviewed and updated to ensure improvements with compliance is effectively implemented	Dec-21		Overdue		Complete		Ongoing highlighting to midwives at a range of forums re compliance with safeguarding supervision. Lead midwife for safeguarding to commence in post 29/08; workplan to include support for supervision. * Rachel Mills lead Safeguarding Midwife will attend monthly Management & Leadership meetings to update the team on Safeguardng cases. * Abbi Maddox Interim Head of Midwifery & Sexual Health to meet with Rachel Mills Safeguarding Midwife on a monthly basis to be sighted on training and required updates. * Learning to be embedded through Joint Shire Meetings with Midwifery & Health Visiting services using Safeguarding scenerios on a quarterly basis. Feb 2023 - update - change in senior management team in January 2023 - management meeting weekly agenda amended to ensure sfaeguarding supervision compliance and any specific updates are standard agenda 2nd week of the month from now on. Safeguarding midwife has database of attendnace at quarterly sessions which will be shared with managment team at those meetings also supporting mechanism for escalation B7 team leads will be expected to feed back monthly on compliance on many elements including safeguarding for their teams safeguarding midwife also booked for March 2023 all Powys team meeting to provide further update for staff around safeguarding advise further embedding of process November 2023 - Safeguarding supervision 85.2% for midwives for Q1Q2 in 23/24. compliance is reviewed monthly at leadership and management meeting. Lead midwife safeguarding sits in safeguarding team, dual workplan between midwifery and safeguarding. Proactively approaching staff to access supervision. Staff do access supervision individually and have access to the hub. Safeguarding covered at whole team meetings and mandatory session at midwifery updates for all midwives.	Issues regarding release of staff due to staff shortages/clinical demand Limited number of sessions which are not always available when convenient for all staff to attend	request that team leads allocate protected time for staff to attend which is rostered, preventing clinical work to be allocated to individual. Lead midwife for safeguarding, to commence in post 29/08, who will support midwives to attend Midwives aware can access safeguarding team re any concerns about specific cases	Expected improvement in compliance by end of Q3; Monitored via Safeguarding Strategic Group and added to W&C dashboards. Feb 2023 - expcted improvement by April 2023 in view of changes in senior structure in Jan 2023		17		May-23	

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		Overdue		Partially complete		Being considered at present and as part of planning for 23/24. April 23 Update - currently being recruited to, Interim Assistant Medical Director appointed Sep 23 1 session per week. Re-advertisement of updated JD 6 sessions to be undertaken q4 23/24	Unable to fully mitigate the risk	During current financial year	30/09/2023		14		May-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		Overdue		Partially complete		currently being scoped. Will need additional finance to resolve or diversion of funds allocated to Health Boards 'back' to afford delivery. Feb 23 update - this is being included as part of our IMTP planning for 23/24. PTHB will apply for additional funding via the Elective Recovery Fund to afford the costs incurred. April 23 update - the Health Board is in the process of applying for it's population share of the £50m to enable this to occur. All schemes likely to start due qtr 1 23/24. Work on repatriation being aligned to GRIFT reviews funding tbc - Nov 23	Currently waiting for NHS Wales DU to assemble patient lists to enable selection from other HB waiting lists (for potential repatriation)		01/06/2023		14		May-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		Overdue		Partially complete		All SLAs to be by the end of Sept as part of managing the overall financial position of the HB. Update - revised focus at CQPRM meetings will see SLA performance discussed more frequently including supplementary operational meetings. There remains a certain level of fragility in the inreach relationships due to at times, a higher level of need withiin the host provider. Feb 23 update - CQPRM meetings include enhanced oversight. the Commissioning Team's programme of work for 23/24 includes a formal review of this area and the application of a consistent approach to all inreach SLA's. On-going review of SLAs - Nov 23	Complexity of multiple in reach providers. Service capacity. DGH fragility.		01/07/2023		14		May-23	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		Overdue		Partially complete		Additional reporting in place and PTHB continues to review compliance against JAG standard. 1 unit now JAG accredited with the 2nd unit seeking accreditation during 22/23			01/04/2023		#VALUE!	#VALUE!	May-23	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		Overdue		Partially 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	Complexity of multiple in reach providers. Service capacity. DGH fragility.		Jun-23		16		May-23	Jan-22
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		At present, 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 that is ongoing in Spet 22. Update - this service is currenty being reviewed as part of the wider ASM work. The eventual model will be incorporated into our OBC	Additional financial resources 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		May-23	Jan-22
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.	Authorisation of new forms at a national level.	Paper forms are currently in use.	TBC - as working to national WCCIS team deadlines.	Jun-23	3		May-23	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.	May-22	Dec-22	Overdue		Partially complete		Some further changes to the document are required. The document will then go through the process that will close with consideration by the Board. We have reviewed the document following completion of our contract award, but also reflected on progress in other HBs -and our document will be finalised and through necessary governance by December 2022	Obtaining an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the revised document by the Board. Extention to deadline requested due to committee timetables.	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	Nov-22		12	5	May-23	Apr-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.					2	2	May-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R6	A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network A review and associated upgrade of Wi-Fi provision should be undertaken	Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Mar-23		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.					2	2	May-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R7	The network should be split into Vlans. The firewalls should be deployed.	Network re-design plane is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	Mar-23		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					2	2	May-23	Sep-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		Overdue		Partially 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					3	3	May-23	Nov-22
222307	Looked After Children Health Assessments	Substantial	Director of Nursing & Midwifery	Director of Nursing and 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		3	3	May-23	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	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	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.					#NUM!	#NUM!	May-23	Mar-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.					#NUM!	#NUM!	May-23	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.					#NUM!	#NUM!	May-23	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.					#NUM!	#NUM!	May-23	Mar-23
222319	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R1	Management should ensure that: • All incidents are managed in accordance with the required timescales; • Staff are clear on how to assess the level of harm caused as a result of the incident • Lessons learnt only state the learning from the incident reported, communicating it to the relevant teams and groups; • Evidence of meetings held should be adequately stored for ease of future use or reference; and • Staff are Root Cause Analysis trained prior to undertaking incident investigations (where required). The formal documentation of the requirement and processes within a Health Board specific procedure (as per recommendation 2.1 below) will provide a platform where the due process can be referred to minimising the findings noted from the review.	Processes to ensure monitoring of timely incident management are established to escalate delays when incidents are not managed and closed within an appropriate timescale. Additional 'Duty of Candour' training sessions have been established during February and March 2023 to ensure classification of harm is addressed appropriately by those reporting (a recording of this session is available to staff unable to attend). Clinical Service Groups to implement a structured process to share learning from incidents. Complete a TNA for all staff investigating incidents to ensure appropriate training has been received.	Apr-23		Overdue		Complete		The Incident Management Framework provides clear guidance to staff, Heads of Service, Service Managers and Governance Leads of the time scales for the management of all levels of harm in incidents. This includes the closue of No Harm/ Low in 7 days, management and assessment of Moderate harm within 5 days in line with Duty of Candour and the timefrmes set out for the reporting of Nationally Reportable Incidents to the NHS Executive. There are two levels of Datix training: For New Users and for Managers, which gives a step by step guide on reporters perception of harm and how the manager should assess this and escalate if required. Upon investigation, the incident investigator will complete the relevant section for lessons learned, which will be communicated to those who have specific access to the incident, a summary of this can then be shared with the reporter. Depending on the level of harm, 7 minute briefings will be cascaded across the relevant service or shared via the Quality and Safety page on the HB intranet. All minutes from incident meetings will be uploaded by the Governance lead to the relevant datix incident in the documents section and a record that a meeting has been held will be added as a progress note. Local Quality and Safety forums are held at service group level that deploy lessons learned and monitoring of action plans that then feed into the monthly Professional Nursing and Midwifery Oversight Group. The Head of Quality and Safety also informs the Executive Committee on a monthly basis of the position on NRI/EWN and Duty of Candour incidents.	No barriers identified	Monitoring is conducted through daily checks of incidents via datix, monthly meetings with Governance Leads and monthly reporting into forums.	MF has been in place with all monitoring mechanisms since August 23		1	1	May-23	May-23
222319	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R3	Acknowledging that developing the datix and incident reporting section of the SharePoint site is a work in progress, management should ensure datix and Incident reporting related pages are reviewed to ensure relevance and ease of use.	Review the reporting section of Sharepoint to ensure appropriate and up to date information is contained within it.	Apr-23		Overdue		Complete		Pages for datix and incident reporting were reviewed and renewed in line with the PTHB Incident Management Framework, which went live in August 2023. This now incorporates training for datix and on the IMF page, staff can find all relevant templates, tools, and training relevant to completing incident reviews, as well as the IMF. This will be continuously reviewed by the Quality and Safety team.					1	1	May-23	May-23
222319	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R4	Management should ensure there is periodic monitoring and reporting of incidents in place at the required forums. Groups should also review and update their ToR as required.	Review reporting structures to ensure consistency and robust reporting processes.	Apr-23		Overdue		Complete		There is monthly reporting at the local CSG level, through PNMOG and the Executive committee.	No barriers identified		Monthly reported.		1	1	May-23	May-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	May-23		Overdue		No progress		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	Daily checks of datix of incidents by governance leads. Monthly reporting through local level Q&S forums, PNMOG and Executive Committee.	Reviewed August 23		0	0	May-23	May-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		Deadline Revised		Partially complete		SOP reviewed and includes the checks that need to take place for invoicing. Self Billing will beimplemented , we are currently going through the testing stage, however the SOP and checks that we currently have in place satisfy the recommendation in terms of checking the invoice. revised implmentation date of February 2024.					#NUM!	#NUM!		
222322	Performance Management and Reporting	Substantial	Director of Performance and Commissioning	Chris Moss	R2	Officer Leads should be identified for all performance measures to ensure Integrated Performance Report narrative sections are comprehensively completed moving forward.	Officer leads are to be confirmed following the Welsh Government release of the 2023/24 NHS Wales Performance framework at the end of June 2023.	Jul-23		Overdue		Complete										
222324	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Helen Bushell	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		Overdue		Partially 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.								
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.								
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.								
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.								
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		No progress		In progress but behind original deadline. Revised deadline of Dec 23								
232403	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Performance and Commissioning	Katie Games	R3	SLAs should be signed off with all providers of In-reach Medical Staff on a timely basis.	To ensure that all agreements signed within financial year. Aim to have timelier sign off of agreements with NHSE providers.	Sep-23		Overdue		No progress		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.								
232404	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Performance and Commissioning	Katie Games	R4	The frequency of meetings should be reviewed to determine what is appropriate to reflect the level of risk for each provider of In-reach Medical Staff and this should then be reflected in the SLAs. Following this, Contract Quality Performance and Review Meetings should be held in line with the frequency specified in the SLAs.	Regular SLA review meetings to be held independently to the CQPRM's. In 2024/25 further alignment of the SLAs to the Integrated Performance Framework.	Sep-23		Overdue		No progress		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.								
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		No progress		We have requested that all providers confirm all applicable checks have been made by them as the employing organisation								

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 being made to implement recommendation Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
192006	Records Management	No Assurance	Director of Finance, Information and IT		R4	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained and that the points raised in this report are addressed, where weaknesses are identified.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Dec-22	Complete	2	Complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the RM Improvement Plan. Detailed actions and lead officers have been identified. Options for on and off-site storage continue to be explored. Process has been implemented through the Property and Accommodation Group that all service requests to store records go via this group for approval. This process ensures the nebecessary risk assessments are undertaken with record to health & safety, security etc. This will also be further progressed through the Digitisation of records project due to commence Autumn 2022 A document and Records Manager has been appointed as a permanent role within the Information Governance Team (commenced February 2022) A digital project manager has been appointed due to start July 2022. Their role will be to project manage the digitisation of records Consultancy was procured to provide a strategic business case overview of current and future recommendates in relation to health records. A business case for the digitisation of records is due to be presented to IBG in August 2022 for funding approval. With a paper going to our Executive Committee thereafter Information Sharing Protocols will be reviewed/developed as part of the Cross Border Project. Business case presented to IBG, funding is still to be secured. Storage of records is identified however requires further funding to address weakness in storage facilities identified. Resource to be prioritised to categorise records within service areas so that destrcution of records where applicable can commence 11/04/23 All storage sites have been identified. Any new requests for records storage are submitted and approved by the Property and Accommodation Group. Embargo on the destruction of records has been lifted, planning underway led by IG to ensure all records over their retention period are destroyed. Remaining records will be appraised and stored appropriately. For offsite and un-manned locations registers are kept of the records held by service, age and type. Any records related risks are logged on local and IG risk registers. In line with NHS Wales NHS Records Management Code of Practice 2022, attention has been brought to a 20-year retention ruling that applies to patients with long term illnesses. Senior level discussions are taking place in terms of how the health board commences the destruction programme and the following actions are being undertaken: · How to identify these cohort of patients. · What is the definition of a long-term condition and the complexities that this will bring to the process.	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed request extension to 31/12/22 The storage of live and inactive records has been identified, this is suitable and secure storage at Spa Road. This will mean that storage will not be needed within Powys County Council buildings. As this is now complete request this action to be closed. The HoIG will work closing with services to ensure records continue to be managed and stored as per policies in place		25	3	Mar-23	14/11/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Dec-22	Complete	2	Complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. Process has been implemented through the Property and Accommodation Group that all service requests to store records go via this group for approval. This process ensures the necessary risk assessments are undertaken with record to health & safety, security etc. This will also be further progressed through the Digitisation of records project due to commence Autumn 2022. Business case presented to IBG, funding is still to be secured. Storage of records is identified however requires further funding to address weakness in storage facilities identified. Resource to be prioritised to categorise records within service areas so that destrcution of records where applicable can commence 11/04/23 A Business case for the Digitisation of Records Project was submitted to the Investments Benefit Group in January 2023 and approved. It was then shared with the executive group for sign off. Due to the high capital costs, investment has been sought from Welsh Government to fund the proposal for 2 years. The decision outcome is waiting to be shared. If this funding is not forthcoming from WG our action plan will need to be reviewed and we will need to be clear on what can be achieved with the current level of resources available by prioritisation. 27/11/23 - The funding required to fully digitalise all in active records and live records is not available at this current time. Secure storage, on and off site is in place for active and archived records. There are discussions at an all Wales level to review records scanning, and the digitalisation of records. So whilst capital is not available in the current climate, locally or nationally, there will be a national approach that PTHB will align to	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed Request this is closed as actions will be captured now via the PM and Records Manager project plan and SIP and covered in the action line above		25	3	Mar-23	26/09/2020
212214	Occupational Health Service	Limited	Director of Workforce and OD	Assistant Director of OD	R1	Management need to ensure that both the Occupational Health Policy and Needlestick & Body Fluid Contamination Injuries Policy are updated and approved in a timely manner.	The Policy for Needlestick and Body Fluid Contamination will be reviewed and presented for Executive approval.The Occupational Health Policy will be reviewed and presented for Executive approval in Quarter 2 2022	Jun-22		Complete		Complete		Needle Stick Injury policy implmeneted. Coprorate Policy covered in follow up Audit - recommendations 22236	Capacity within the OH team has meant this has only partly been achieved		Generic OH policy review will be ready for consulation / comments end Aug with view to approval by execs in Sept	Exec meeting 13th July NS and BF policy approved	11		May-23	Aug-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R1	A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.	Original replacement plan was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Secured DPIF Capital funding in 21/22 to help improve and enhance current infrastructure (but not to fully rectify and resolve), global market conditions and supplier delays resulted in alternative plans being deployed (linked to infrastructure development) to maximise use of the funding as available within time constraints. Further DPIF bids are being prepared for submission in 23/24 and beyond. There are also plans to move to the HCI platform to allow the legacy equipment to be decommissioned. This will also improve power and cooling.A realistic infrastructure replacement plan is being developed linked to the 4C report and this will be across a number of years and potential funding sources available.	Mar-23		Complete		Complete		2008 servers identifed and some have already been upgraded/migrated and there is a plan to refresh all Windows 2008 servers 11/04/2023 - There are currently 6 Server 2008 servers in use. We are working with suppliers and internal teams to remove the remaining servers. This figure is down from 10 at the beginning of march. Work continues to remove Windows Server from the estate as quickly as possible. 27/11/2023 - All Windows 2008 have been replaced/upgraded, there are 2 remaining which are scheduled and will be completed as part of the planned telephony upgrade this FY 23/24.					2	2	May-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R4	A process for ensuring patching of switches should be established.	Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid.	Mar-23		Complete		Complete		Capital is sourced to replace part of the switch estate. Further funding is being sought for ongoing Switch replacement 11/04/2023 - A significant investment has been secured to replace switches in various location around the authority. A process for maintaining firmware willl be devised during rollout. 27/11/2023 - The process for maintaining firmware is in place, there is also a rolling programme to replace switches in need of upgrading, so all patching is up to date and there is a legacy switch replacement programme ongoing					2	2	May-23	Sep-22
222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Head of Financial Services	R5	Management may wish to consider the development of a sign off checklist to concisely summarise when supporting documentation was completed and where it is located.	Agreed a template will be developed and retained for approvals and subsequent actions and dates taken on these approvals	Mar-23		Complete		Closed		This has been completed there is now a spreadsheet detailing the approvals and subsequent payment number and dates for expenditure items by each fund					2	2	May-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R3	Management to ensure that the Welsh Language Policy along with any staff guidance is up to date, accurate and published as soon as possible on SharePoint for point of reference for all staff. The existing Health Board response to this standard has taken the form of a mangers' guidance document, however the Audit has called for a formal policy; the Welsh Language Team will develop this using models from other Welsh health boards.	The Welsh Language Team will develop a formal Welsh language policy summarising the Health Board's position.	Jan-23		Complete		Complete		Policy Approved April 2023				Policy available on Sharepoint.	4	4	May-23	Jan-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director and Head of Therapies	R1	Review and finalise current policies and procedures and ensure they are referenced within the Professional and Clinical Governance Framework.	The organisation Professional Registration policy review is to be finalised The organisation Clinical Supervision procedure review is to be finalised Both documents to be referenced in the overarching framework document referenced in Matter Arising 2.	Jul-23		Complete		Complete		Professional Registration Policy and Clinical Supervision Policy finalised, approved and published.							May-23	Mar-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Professional Heads of Service	R4	Management should ensure that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Professional Heads of Service to provide assurance that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Oct-23		Complete		Complete		Assurance received through Professional Governance frameworks at individual professional governance level. Revised clinical supervision policy also supports assurance against this requirement.							May-23	Mar-23
222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director and Head of Therapies	R1	Review and finalise current policies and procedures and ensure they are referenced within the Professional and Clinical Governance Framework.	The organisation Professional Registration policy review is to be finalised The organisation Clinical Supervision procedure review is to be finalised Both documents to be referenced in the overarching framework document referenced in Matter Arising 2.	Jul-23		Complete		Complete		Professional Registration Policy and Clinical Supervision Policy finalised, approved and published.							May-23	Mar-23
222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Professional Heads of Service	R4	Management should ensure that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Professional Heads of Service to provide assurance that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Oct-23		Complete		Complete		Assurance received through Professional Governance frameworks at individual professional governance level. Revised clinical supervision policy also supports assurance against this requirement.							May-23	Mar-23
222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R1	The TSU's approach to engagement with service users, including ward management and bank staff requires a review, to ensure the team are continually striving to meet the needs of the Health Board, informed by service users.	Implement a structured programme of engagement with regular users of the TSU service in addition to the 3 times a week staffing huddles. Set up Yammer for engagement with staff.	Jun-23		Complete		Complete		Staffing Huddles take place every Monday and Friday with the Commuinity Service Managers, every Monday and Thursday with the Mental Health Service Managers, every Friday with the Theatre service managers. In addition to this TEAM channels with the wards. Yammer has been set up for Bank staff to use and a sharepoint site has also been set up for bank staff, this page includes useful information.								
222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R2	Management need to consider utilising the TRAC Management Update Report to monitor the PEC stages. The data is more accurate, it is a more efficient process and will help to reduce discrepancies.	Trac report to be run on a Monday morning each week and used to update the TSU Recruitment Tracker for monitoring and corrective action.	Jun-23		Complete		Complete		Recruitment tracker is updated using Trac - this is done as part of the daily tasks within the team								
222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R3	Management need to review the current bank staff recruitment process to identify the issues that are causing delays. Appropriate actions then need to be implemented to address the issues and allow for improved compliance with the KPI's.	Weekly internal recruitment meetings to be held with members of the TSU to review and analyse the TSU Recruitment Tracker report to monitor performance and take corrective action for areas causing delays. KPI report to be produced and monitored weekly to monitor compliance.	Jun-23		Complete		Complete		KPI' s introcudes in line with susbtatnive recruitment time to hire KPI. Weekly internal team meetings take place on a Friday to discuss recruitment, following this meeting any issues around delays can be escalated to the Resourcing Manager.								
222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R4	Management need to agree on an identifiable reference for storing approving emails. This will improve the process of locating the email trails within the generic email address.	Unique reference to be included within the subject box for all email shift requests for on and off contract agencies. On and off contract agency approval at 3 times a week Staffing Huddles with CSMs will be confirmed in an email.	Jun-23		Complete		Complete		Since the introduction of Sysaid the unique reference is included on shift requests. .								

222320	Temporary Staffing Unit	Reasonable	Director of Workforce and OD	Human Resources Business Partner	R6	Management should ensure that accurate and timely reports on bank and agency usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board.	Dashboards to be produced for nursing wards, Mental Health, facilities, AHP. These dashboards will show the bank and agency usage/costs, fill rate.	Jun-23		Complete		Complete		Overall bank and agency reports are prodcued and shared with the service areas.								
222325	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Helen Bushell	R3	The RAG membership should be appropriately reconstituted and its ToR should be revised accordingly so as to ensure a prompt reactivation of its roles and responsibilities in respect of risk management oversight and reporting. Additionally, until the RAG is reconstituted the Executive Team should be formally advised that the Group has not been operating or delivering its mandate as prescribed within its current ToR.	Engagement with Executives is currently underway to reconstitute the Group and inform a refresh of the ToR to ensure its roles and responsibilities in respect of risk management oversight and reporting are fit for purpose. Subject to approval of the revised ToR by the Executive Committee, the first meeting of the refreshed Group is due to be held on 12 September 2023 and on a bi-monthly basis thereafter.	Sep-23		Complete		Complete		Nov 2023 - the RAG has been restablished and meeting again from Sept 2023, the Director of Corporate Governance is the Chair. The terms of reference have been updated.								
222326	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Louise Turner	R4	Mental Health Management should consider if the Adult Mental Health Services, Learning Disabilities Service and Integrated Autism Service departments should each introduce a risk register so as to provide a uniformity of approach to risk management within Mental Health, and thereby ensure that their respective risks are formally scored, recorded and subjected to action planning in accordance with the Risk Management Framework and Toolkit.	It appears that the Psychology service have developed a risk register to assist their own future planning. We do not require the individual mental health service functions with the Mental Health Directorate to maintain individual risk logs. The process for managing risks within the service groups is for each service/team escalate operational risks to the Operational Management Team, and for risk scoring over 12 to be escalated to the Senior Management Team Risk register. Team managers and service leads from each speciality are represented at OMT. The consequence of a risk register for each service function would result in approximately 15 registers to maintain, an may introduce the risk of missing any escalation/risk management by the existence of multiple registers.	Jul-23		Complete		Complete		Nov 2023 update - SMT structure created that allows for local risk escalation to be considered at sub groups which will each have a risk register for their areas of work and will be submitted to SMT for governance purposes								
222327	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Louise Turner	R5	Additionally, a ToR should be produced for the Adult Mental Health Service OMT to provide a formal structured outline of its roles and responsibilities for risk management oversight and reporting within the department and the Mental Health SMT ToR should be revised and updated accordingly to reflect any changes in its constitution or mandate, and specifically any regarding risk management oversight.	We agree that a ToR for OMT is required, and this is in development.	Jul-23		Complete		Complete		Nov 2023 update - 2.OMT terms of reference have been created and agreed by SMT								
222329	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R1	Whilst we acknowledge that the Health Board went into financial recovery mid-year and new non recurrent schemes were identified, robust recurrent savings plans will need to be identified to enable the Health Board to achieve a breakeven position going forward.	Agreed. Thé Health Board has set an ambitious recurrent £7.5m saving target in 2023/24 as part of its financial plan, which is a deficit of £33.5m As at month 2, £6.9m of savings assessed as Green and Amber schemes are being implemented and a further £1.9m pipeline of ideas (Red) are being explored. A deadline of agreeing a full programme of £7.5 m recurrent schemes has been agreed for 31 July 2023. This will require the continued active involvement of all areas of the Health Board and will be co-ordinated and monitored by the Deputy Director of Finance and the Finance Directorate.	Jul-23		Complete		Complete		A full programme of saving schemes has been developed for 2023/24. The achievement of savings is monitored on a monthly basis.								
222330	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R2	The Finance team must continue to support individual Directorates to maintain continuous pipeline opportunities but clear lines of accountability for completing plans and actions need to be developed and completed to help deliver the plan.	A paper to agree the savings and efficiency approach for 2023/24 has been approved by the Executive Committee. It is a continuation and enhancement of the work, which was initiated during 2022/23 when the organisation forecast that it would be in financial deficit. The paper clearly sets out the target areas to achieve £7.5m, which had been developed through consultation with the Board. Clear lines of accountability are articulated, for example, the Executive lead for each workstream. The finance business partner team will continue to provide active support to each workstream.	Jun-23		Complete		Closed										
222331	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R3	Management need to revisit the Efficiency Framework and refresh the document so that it is in line with where the Health Board is now. Clear guidelines need to be established on what groups are needed to help manage the plan and to keep the process visible.	A paper to agree the savings and efficiency for 2023/24 has been approved by the Executive Committee. It is a continuation and enhancement of the work, which was initiated during 2022/23, when the organisation forecast that it would be in financial deficit.	Jun-23		Complete		Closed										
222332	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R4	Management must ensure that the narrative supporting the savings plan in the Financial Performance Report is reporting the correct position and that it tallies with the corresponding tables.	Agreed. Performance reporting will be enhanced in 2023/24 to ensure accurate, consistent and timely reporting of the savings position is reported to all stakeholders.	Jun-23		Complete		Complete		The finanical report to Executive Committee and to Board has been revised for 2023/24. There is a clear focus upon the savings programme.								
222333	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R5	Management should consider incorporating the Financial Saving Schemes RAG rating definitions into the monthly 'Finance Report', to enhance transparency within the publicly available paper.	A reference and link to the All Wales guidance on RAG ratings will be provided in the report.	Jul-23		Complete		Complete		Done.								
222334	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R6	Management must ensure that there is supporting documentation available to validate each of the schemes identified in the Savings Tracker.	Service leads and their associated Finance Business Partner will ensure that supporting documentation evidencing the level of savings achieved will be filed on the HB's Sharepoint and readily accessible.	Jul-23		Complete		Complete		Done. Working papers are retained, which evidence the level of savings achieved.								
222335	Savings Plans and Efficiency Framework	Reasonable	Director of Finance, Information and IT	Hywel Pullen	R7	Management must ensure that the correct RAG rating is allocated to each of the schemes on the Savings Tracker.	The RAG ratings of schemes will be reviewed and reported on a monthly basis, by the Finance team in co-ordination with the manager responsible for the savings scheme.	Jul-23		Complete		Complete		Done.								
222336	Follow Up: Occupational Health Service	Reasonable	Director of Workforce and OD	Helen Hine/Sarah Powell	R1	Management need to ensure that the Occupational Health Policy is reviewed, updated and approved as soon as possible.	The Occupational Health policy will be re written and consulted on by end of June The policy will be presented to Executive committee for approval sign off in July	Jul-23		Complete		Complete		COMPLETE - NOVEMBER : OH policy reviewed and submitted to Execs for approval 29.11.23								
222340	Internal Audit Recommendation Tracking	Reasonable	Director of Corporate Governance/Board Secretary	Interim Corporate Governance Manager	R1	Management should ensure that all the Internal Audit recommendations within the final reports are accurately recorded within Appendix A of the Audit Recommendation Tracking Report.	A review of the data held within the tracker will be undertaken to ensure accuracy for all reporting years, particularly where reporting can be simplified to reduce duplication of data and likelihood of errors. A lessons learned exercise will be undertaken to identify where errors have occurred. A review of data quality is undertaken on an annual basis, this will continue to be undertaken.	Oct-23		Complete		Complete		Nov 2023 update - the report production process has been reviewed and report simplified. The desk instructions have been updated to support the production of the report.								
222341	Internal Audit Recommendation Tracking	Reasonable	Director of Corporate Governance/Board Secretary	Interim Corporate Governance Manager	R2	Management should ensure that calculation checks are undertaken on the information detailed within the Audit Recommendation Tracking report before it is submitted for consideration by the Committee.	Reports are quality checked prior to presentation to Committee, however work will be undertaken to enhance this process. A step by step guide for checking the mathematical accuracy of reporting will be produced to support this process.	Oct 23		Complete		Complete		Nov 2023 update - the report production process has been reviewed and report simplified. The desk instructions have been updated to support the production of the report.								
222342	Internal Audit Recommendation Tracking	Reasonable	Director of Corporate Governance/Board Secretary	Interim Corporate Governance Manager	R3	Management should make sure that robust checks are undertaken to ensure that all recommendations completed are accurately and consistently recorded in Appendices A and E of the Audit Recommendation tracking report.	A lessons learned exercise will be undertaken to identify where errors have occurred. As per recommendation 1.2 further work will be undertaken to enhance the review process.	Oct-23		Complete		Complete		Nov 2023 update - the report production process has been reviewed and report simplified. The desk instructions have been updated to support the production of the report.								
222343	Internal Audit Recommendation Tracking	Reasonable	Director of Corporate Governance/Board Secretary	Interim Corporate Governance Manager	R4	Management should consider allocating time for an in-depth review of the report by the Audit, Risk & Assurance Committee at least once each financial year.	A review of the work programme has been undertaken to identify a suitable opportunity to allocate sufficient time at Committee to undertake an in-depth review – this has been added for January 2024.	Oct-23		Complete		Complete		Nov 2023 update - the January Committee meeting will be the annual in depth review point.								
232407	Clinical Audit	Reasonable	Medical Director	Howard Cooper	R1	Management should ensure that the Clinical Audit page on the Intranet is reviewed and updated to reflect the issues identified above.	The requested changes to the web site have been made.	Completed		Complete		Closed										

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 interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
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.	Dec-23		Not yet due		Partially complete		Business cycle from April 2023 will include cycle of site based audits for review by the group to establish annual reviews. 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.					#NUM!	#NUM!	May-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Strategy, Primary Care and Partnerships	Director of Environment	R1	PTHB should look to formalise Decarbonisation oversight arrangements within the Terms of Reference of existing committee/ meetings.	The Environment Sustainability Group (chaired by the Director of Environment) provides escalate/exception reports to the Innovative Environments Group (chaired by CEO) and then on to the Delivery and Performance Committee.When terms of Reference are reviewed at normal intervals the need to be more specific about reporting detail will be considered.	Oct-23		Not yet due		Complete		ToR for Environment and Sustainability Group will be updated in Q2 for approval by Q4. Agreed process for model of alternate meetings with core and full ESG attendance					#NUM!	#NUM!	May-23	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.	Dec-23		Not yet due		Partially complete		Outcome will be dependent upon changes made during 2023. A review on the DSDP is now due in 2024 with outcomes expected to be realigned with missed targets by some HBs and more granularity of carbon emissions.					#NUM!	#NUM!	May-23	Nov-22
222311	North Powys Wellbeing Programme	Reasonable	Associate Director of Capital, Estates and Property	Senior Responsible Officer	R5	An updated benefit framework should be developed to ensure clarity and relevance to the phase of the Programme but most importantly to meet with the overall desired outcome of the North Powys Wellbeing Programme	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	Dec-23		Not yet due		No progress					Awaiting guidance from Programme Boards for each decarb stream and updated DSDP.			#NUM!	#NUM!	May-23	Jan-23
222316	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R2	Management should work towards producing an Incident reporting Standard Operating Procedure which will bring together (in one place) a standardised and clear system.	Production of an incident management framework.	Jun-23		Not yet due		Complete		The Incident Management Framework provides clear guidance to all staff and is available via the Quality and Safety page on the Health Board intranet. This was published in August 2023.	No barriers identified				#NUM!	#NUM!	May-23	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.					#NUM!	#NUM!	May-23	Mar-23
222319	Incident Management	Reasonable	Director of Nursing & Midwifery	Assistant Director of Quality and Safety	R2	Management should work towards producing an Incident reporting Standard Operating Procedure which will bring together (in one place) a standardised and clear system.	Production of an incident management framework	Jun-23		Not yet due		Complete		This is complete. This has been through consultancy in July and approved by the Board. This went live in the organisation in August 2023 and is accessible through the Quality and Safety page on the PTHB intranet.	No barriers identified		Active since August 2023		#NUM!	#NUM!	May-23	May-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		The IPF has been implemented but the Power BI supporting solution is behind timescale. The latter being reworked into a new timetable. The supporting IT solution has not prevented the rollout of the IPF								
222323	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Helen Bushell	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		Not yet due		Partially 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								
222328	Risk Management and Board Assurance Framework	Reasonable	Director of Corporate Governance/Board Secretary	Helen Bushell	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.								
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		No progress		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.								
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		No progress		This is linked to action 232402 and 232404								
232408	Clinical Audit	Reasonable	Medical Director	Kate Wright	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		No progress										
232409	Clinical Audit	Reasonable	Medical Director	Kate Wright	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		Not yet due		No progress										
232410	Clinical Audit	Reasonable	Medical Director	Kate Wright	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.	Dec-23		Not yet due		No progress										
232411	Clinical Audit	Reasonable	Medical Director	Kate Wright	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.	Dec-23		Not yet due		No progress										

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	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
181951	Structured Assessment 2018		Director of Corporate Governance/Board Secretary		R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Overdue	2	No progress		Remains under review - with the approach to stakeholder engagement being formalised. Feb 2023 update - status remains as reported above, the action will form part of the 2023/24 work programme which will consider the most appropriate mechanism to achieve the aims and objectives of a Healthcare Professionals Forum. REVISED DATE REQUESTED of 30/9/23. November 2023 update - the revised 2023/24 plan reset, approved by the Board on the 29 November results in this action being deprioritised from the 2023/24 Annual delviery plan. This item will therefore be moved into 2024/25, revised date of 30/9/2024. April 2023 update - udpate as above in Feb 2023. The recommendation has been reinforced in the 2022 Structured Assessment report. A decision will be made and implemented by the revised due date of Sept 2023.	Delayed in light of COVID-19 and changes in the corporate team	Clinical and Stakeholder engagement is undertaken via other means	30-Sep-23		43	26	May-23	
202152	Structured Assessment 2020		Director of Corporate Governance/Board Secretary		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	•Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.	Mar-22		Overdue	2	No progress		See R2 above Feb 2023 update - as above in R2, REVISED DATE REQUESTED of 30/9/23. April 2023 update - as above in R2. November 2023 update - the revised 2023/24 plan reset, approved by the Board on the 29 November results in this action being deprioritised from the 2023/24 Annual delviery plan. This item will therefore be moved into 2024/25, revised date of 30/9/2024.	See R2 above	See R2 above	See R2 above		14	1480	May-23	
222301	Reviewing public bodies' current approach for conducting EIAs		Director of Corporate Governance/Board Secretary		R4	While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach.	Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.	Ongoing		Overdue		Complete		November update - Process has been reviewed and an EIA process now in place and being rolled out across teams	None		fully rolled out by Qtr 1 23/24		#VALUE!	#VALUE!	May-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R1	All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.		Ongoing		Overdue		Partially complete							#VALUE!	#VALUE!	May-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R2	Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.		Mar-23		Overdue		Partially complete							1	1	May-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R3	Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.		Ongoing		Overdue		Partially complete							#VALUE!	#VALUE!	May-23	Nov-22
222303	Review of the Strategic Renewal Portfolio		Director of Strategy, Primary Care and Partnerships		R1	Independent members were engaged in the development of the Annual Plan for 2021-22 and the renewal priorities. However, since this time there has been a change in the independent member cadre. The Health Board should refresh the independent member awareness. This would ensure new and existing members have continued ownership, knowledge, and challenge.		Ongoing		Overdue		Partially complete		As part of IMTP planning for 23/24 and the wider focus on system working, PTHB has embarked on a piece work look at long term sustainability of services. This piece of work titled "Accelerated Sustainability Model" will include a review of our Strategic Renewal Portfolio. IM's have been fully involved in the production of the 2324 Integrated Plan through a series of Board Development Sessions that started in Oct 22 and finished in March 23			By end of Mar 23		#VALUE!	#VALUE!	May-23	Jan-23

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					

NO RECOMMENDATIONS 'NOT YET DUE'

Mills Belinda
15/01/2024 09:45:47

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 being made to implement recommendation				If action is complete, can evidence be	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implemmntation?	When will implementation be achieved?					
212214	Occupational Health Service	Limited	Director of Workforce and OD	Assistant Director of OD	R1	Management need to ensure that both the Occupational Health Policy and Needlestick & Body Fluid Contamination Injuries Policy are updated and approved in a timely manner.	The Policy for Needlestick and Body Fluid Contamination will be reviewed and presented for Executive approval.The Occupational Health Policy will be reviewed and presented for Executive approval in Quarter 2 2022	Jun-22		Complete		Complete		Needle Stick Injury policy implmeneted. Coprorate Policy covered in follow up Audit - recommendations 22236	Capacity within the OH team has meant this has only partly been achieved		Generic OH policy review will be ready for consulation / comments end Aug with view to approval by execs in Sept	Exec meeting 13th July NS and BF policy approved	11		May-23	Aug-22

Archwilio Cymru
Audit Wales

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

Date issued: January 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 Accountability Report and Financial Statements	Director of Finance, Information and IT	Statutory audit of the financial statements to inform the audit opinion.	Audit Completed in July 2023 and the AGW signed the accounts on 27 July. He issued an unqualified 'true & fair' opinion, and qualified the regularity opinion as the Health Board breached is revenue resource limit for the 3-year period 20-21 to 22-23	Complete
Audit of the Charitable Funds Financial Statements	Director of Finance, Information and IT	Audit of the financial statements to inform the audit opinion.	Audit work ongoing, to meet the statutory deadline of 31 January 2024.	January 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. 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). 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).	Blog and data tool published in April 2022 Part 1 - Fieldwork complete and report drafting now underway. Part 2 – Project Brief issued	March 2024
Primary Care Services -	Interim Director of Operations	In 2018, we conducted a review of primary care services, specifically considering	Report being drafted	March 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow-up Review		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.		
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.	Report being drafted	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. This work will also include a review of the arrangements that are in place to track progress against previous audit	Report issued in draft	March 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		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	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Fieldwork underway	March 2024
All-Wales thematic review of planned care	Interim Director of Operations	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local work	To be confirmed	The precise focus of this work will be agreed with executive officers and communicated to the Audit and Risk Assurance Committee.	Not yet started	To be confirmed

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
Corporate Joint Committees – commentary on their progress | Audit Wales	November 2023

Additional information

7 There have been no corporate documents published by Audit Wales since the last committee update.

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8

Audit Risk and Assurance Committee	**Date of Meeting: 16th January 2024**
Subject:	**Counter Fraud Update Report**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2023/24.
RECOMMENDATION(S):
It is recommended that the Audit Risk & Assurance Committee: • **receive** the report for discussion; and • take **assurance** that appropriate counter fraud systems are in place.

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	✓				

Item 3.8

Counter Fraud Update Report

16 January 2024

1. INTRODUCTION

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

2. BACKGROUND

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

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

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below. Figures are correct as of 04 January 2023.

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	**40**	**25**
Inform and Involve	**68**	**25**
Prevent and Deter	**100**	**31**
Hold to Account	**100**	**42**
TOTAL	**308**	**118**

The resource utilisation is below expected delivery level at this point in year due to Local Counter Fraud Specialist leaving post with a short gap before replacement recruited. Additionally, the replacement Local Counter Fraud Specialist has been on long term sick leave due to a serious medical emergency.
Discussions have been held with Director of Finance around the loss of resource and expected slippage in delivery of the Counter Fraud Workplan. The Local Counter Fraud Specialist is due to return to work in January 2024.

4. STRATEGIC GOVERNANCE

The Head of Counter Fraud Services was engaged with a consultation process being undertaken in relation to counter fraud arrangements in NHS Wales. This followed presentation of a paper to the November 2022 Directors of Finance Forum, which was also reviewed at the Counter Fraud Steering Group. The paper was prepared at the request of Directors of Finance and as well as setting out the current arrangements, it also included some initial considerations regarding the future provision of the services. The consultation meeting centred around discussion of 3 options developed in this Forum paper:

Option 1	**No change –** continue with the current three tier service provided via CFS Wales, LCFS and NHSCFA. Smaller health bodies continue to buy in their LCFS service from the larger health bodies, for example, DHCW and HEIW buy in their LCFS services from C&V UHB.
Option 2	**Hybrid system** – all health bodies have the **option** to opt into a NWSSP led service. LCFS services provided by NWSSP would retain a local presence at the health bodies they represent, maintaining a strong operational relationship with the relevant Finance Directors. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.
Option 3	**Centralised Model** – CFS Wales and **all** LCFSs move across to an NHS Wales Shared Service Model which retains a strong local presence at the relevant health bodies, similar to the current NWSSP procurement provision. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

Key stakeholders have been engaged to determine views on the current arrangements and the relative merits of the options included in the DoF Forum paper. A consultation report was then presented presentation at DoF Forum.

The Head of Counter Fraud Services subsequently attended a NHS Wales Counter Fraud Steering Group meeting where discussions were held around the paper previously presented to DoF Forum regarding counter fraud arrangements in NHS Wales. The discussions concluded with an agreement to pursue wider consultation with the NHS Counter Fraud community and other stakeholders via engagement workshops. The intent is to develop a 5 year vision for NHS Counter Fraud Services alongside an achievable roadmap.

This presents an opportunity to shape the Counter Fraud provision within NHS Wales to ensure the service remains able to respond to emerging fraud risk in an evolving environment. The wider consultation is being led by the Director of Finance at DCHW and is welcomed by the NHS Counter Fraud Community.

5. INFORM AND INVOLVE

The Counter Fraud Team participated in International Fraud Awareness Week which ran 13-19 November. A articles and communications around NHS fraud risk were disseminated before, during, and after the week.

The Counter Fraud Team continue to deliver fraud awareness sessions as part of the Health Board's corporate induction as well as delivering a session as part of the Health Board's managers cohort training via Finance link.

The Counter Fraud Team have made engaged with the Primary & Community Academy and made arrangements to deliver training to GMS contractors. Further training will be developed for delivery to other Primary & Community contactors into 2024/25 via this established link. All training will be bespoke to cover risks each business area is exposed to.

6. PREVENT AND DETER

Staff surveys are being developed for completion in Q4. Surveys will be aimed at business areas who have missed direct counter fraud input in year aiming as well as high risk staff groups identified via risk assessment work. Survey results will feed into planning for prevent and deter as well as inform and involve work plan activity for 2024/25.

7. HOLD TO ACCOUNT

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

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

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

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

8. RECOMMENDATION

The Audit Committee is asked to:

- receive the report for discussion; and
- take assurance that appropriate counter fraud systems are in place.

Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/23/00424	01/03/2023	Expenses	Staff	Multiple Staff claiming full rate mileage expenses for excess mileage entitlement	Investigations have sought to confirm knowledge of claim procedure. Evidence has been discovered of staff members questioning process with managers and requesting additions to e-expenses account to enable claim to be made under excess mileage. In absence of evidence of criminal dishonesty civil recovery route available. Confirmation is being sought that repayment has been made of the overclaimed expenses.
INV/23/01425	20/07/2023	Dental	Contractor	Dental contractor alleged to be inflating treatment banding	Information has been disclosed to Primacy Care and Medical Director. An analysis of treatments is being undertaken by NHS BSA Dental Advisor to inform investigation. This analysis is due to be completed by end of January 2024.
INV/23/01876	05/09/2023	Leave/Absence	Staff	Staff member has used allocation of leave intended for Bank Holiday allowance as normal annual leave	Enquiries undertaken around leave records at Health Board and previous employer, another NHS Wales Health Board. Investigation produced evidence from the Health Board and previous employer that this was an isolated incident. Disciplinary action resulted in informal action with agreement to repay 7 days of leave from 2022/23. Confirmation is being sought that repayment has been made.
INV/23/01918	12/09/2023	Qualifications	Contractor	Doctor alleged to have falsified qualifications	Given circumstances an immediate disclosure was made to Primary Care and Medical Director. A review of documentation, including qualifications, submitted for admittance on performers list was undertaken and enquiries with GMC made

Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
					promptly. No issues or concerns were established with these enquiries and no evidence was established to warrant action against doctor at that stage. A meeting has been held with Practice Manager and no concerns have been established following this. Enquiries are being undertaken to test and confirm validity of qualifications held by the doctor. Request for information has been sent to Irish Medical Council who have been slow to provide response. A further meeting has been arranged between Primary Care, Counter Fraud and Practice Senior Partner to discuss.
INV/23/01970	13/09/2023	Overpayment of Salary	Staff	Staff member terminated by Health Board continued to be paid for 8 months	Subject was dismissed due to working without correct immigration status. Subject has been traced via Home Office who confirmed issuance of a new visa and is believed to be in UK. Investigation to be undertaken by NHS CFS financial investigator who is seeking to trace whereabouts.
INV/23/02632	22/11/2023	Fraudulently Amended Medical Records	Staff	The medical records of a patient have been amended with allegations that files have been deleted, and/or fabricated in order to imply that they have mental health issues	Information received via Fraud and Corruption Reporting Line. Enquiries have been undertaken with the NHS CFA Central Intelligence Unit, who received the report, to ascertain any further details such as those of reporting person. None were available. Investigation is to seek patient records for the individual to conduct review. This is difficult without direct consent due to duty of confidentiality rules.

Open Cases					
Reference	Date Commenced	Fraud Type	Subject Type	Allegation	Status
INV/23/02673	24/11/2023	Working Elsewhere Whilst Sick	Staff	Two Staff members absent due to sickness were seen to be working during sick period	Investigation has commenced with approach to a witness. Further witnesses were identified following this discussion who will now be approached.
INV/23/02770	06/12/2023	Overbilling	Contractor	Contractor via All Wales contract has overinflated claims for services provided	Allegations centre on 'double booking' charges for services provided and charges for services not provided. A meeting was held with contract manager who disclosed that this contractor had separately identified significant value of charges that needed to be returned to the NHS across Wales. The contract manager is to meet the contractor to discuss particular concerns raised and ascertain any service issues linked to charges being claimed and subsequently returned. Additionally, contractor has expressed difficulties to contract manager around access to sites at times. Non-access to site would be chargeable under contract. Given potential All Wales nature of this concern information was discussed with CFS Wales. LCFS and CFS Wales in agreement that issue appears to be contract management issue at this stage and should initially be addressed under those processes. Counter Fraud to review progress of this process.
INV/23/02907	03/01/2024	Working Elsewhere Whilst Sick	Staff	Staff member absent due to sickness has been working during sickness period	Initial enquiries have commenced to corroborate allegation.

Agenda item: 3.09

Audit, Risk and Assurance Committee	Date of Meeting: 16 January 2024
Subject:	**PTHB BOARD MEMBER DECLARATION OF INTERESTS – 2023/2024 and PTHB DECLARATION OF GIFTS AND HOSPITALITY – 2023/2024**
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 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.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the contents of Register of Interests and Register of Gifts and Hospitality for PTHB Board Members at 31 December 2023, and;
- take **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.

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:

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

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

DETAILED BACKGROUND AND ASSESSMENT:

In accordance with the requirements of the health board's Standing Orders and Standards of Behaviour Policy (attached at **Appendix A**) a report is required to be received by the Audit, Risk and Assurance Committee which details the Declarations of Interest received by Board Members and Register of Gifts and Hospitality.

The Register of Interests and Register of Gifts and Hospitality is maintained by the Corporate Governance Department with each Declaration reviewed and checked by the Board Secretary with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests. The register

of Interests for 2023-2024 as at 31 December 2023 is attached at **Appendix B.** The Register of Gifts and Hospitality as at December 2023 is attached at **Appendix C.**

Declarations of Interest

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

A process is in place by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted.

In line with the Cumberledge Review, the Corporate Governance Team is also pursuing best practice and encouraging all staff to declare interests where applicable, in the future this will particularly apply to Consultants and Doctors and the likely vehicle to record declarations in the future will be the organisations HR system – ESR. To support the transfer to any new system and the widening of the collection of declarations, work is underway to develop a Communications plan, and to streamline the process of which Declarations are made and recorded.

The Director of Corporate Governance has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on the health board's website to ensure openness and transparency **here.**

Gifts and Hospitality

All employees of the Health Board must consider their position carefully before accepting any gifts or offers of hospitality. They must avoid situations where the acceptance of gifts or hospitality might be perceived to influence a decision in respect of purchasing goods or services, awarding contracts, making appointments or treating patients.

The register is attached reflecting the declared gifts and hospitality for the reporting period.

NEXT STEPS:

The Register of Declaration of Interests (Board Members) for 2023/2024 will continue to be published on the PTHB website and will be maintained up to date by the Corporate Governance team.

The Register of Declaration of Gifts and Hospitality for 2023/2024 will continue to be published on the PTHB website and will be maintained up to date by the Corporate Governance team.

STANDARDS OF BEHAVIOUR POLICY
INCORPORATING DECLARATIONS OF INTEREST, GIFTS, HOSPITALITY AND SPONSORSHIP

Document Reference No:	PTHB / CGP 003	
Version No:	Issue 2	
Issue Date:	June 2019	
Review Date:	June 2022	
Author:	Board Secretary	
Document Owner:	Corporate Governance/Board Secretary	
Accountable Executive:	Board Secretary	
Approved By:	Board	
Approval Date:	31 July 2019	
Document Type:	Policy	Non-clinical
Scope:	PTHB Staff and Independent Members	

The latest approved version of this document is online.
If the review date has passed, please contact the Author for advice.

Version	Summary of Changes/Amendments	Issue Date
1	New Policy	2015
2	• The Policy has been strengthened in respect of Secondary Employment & Private Practice, Social Networking Sites, Use of PTHB Logo, Rewards for Initiative and Gifts and Hospitality. • The Policy has been updated to ensure consistency across Health Boards in NHS Wales. • With regard to Gifts from Service Users or their Relatives, the value of gift tokens for acceptance has been removed (from £25 to £0, in-line with NHS England Guidance and NHS Wales).	2019

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Board Secretary
Head of Local Counter Fraud Services

Circulated to the following for Consultation

Date	Role / Designation
03/07/19	Executive Committee
08/07/19	Workforce Policy Review Group
16/07/19	Audit, Risk & Assurance Committee

Evidence Base
• Commercial Sponsorship - Ethical Standards for the NHS, Department of Health; • Code of Conduct and Accountability, Welsh Assembly Government, 2003; • WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry; • WHC (2006) 090 The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 • The health board Standing Orders & Standing Financial Instructions • Bribery Act 2010 • General Medical Council Good Medical Practice Guidance – Financial and Commercial Arrangements and Conflicts of Interest, 2013 • Nursing & Midwifery Council Gifts and Gratuities Guidance, September 2013 and The Code: Standards of Conduct, Performance & Ethics for Nurses & Midwives • Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016 • Overpayments Protocol (NHS Wales Shared Services Partnership) • All Wales Code of Conduct (Business) for NHS Staff • Prevention of Fraud, Bribery and Corruption • Commercial Sponsorship – Ethical Standards for the NHS • NHS England - Guidance on Managing Conflicts of Interest in the NHS

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** PTHB is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees, reflects their individual needs and does not discriminate against individuals or groups.
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and Maternity	x				
Race	x				
Religion or Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and Civil Partnership	x				
Welsh Language	x				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? The register of interests for Board Members will be available for public scrutiny and will be published on Powys teaching Health Board's (PTHB) website, in accordance with the General Data Protection Regulation (EU 2016/679) and data protection legislation. The register of interests for staff will contain personal identifiable information of not only staff members but also possibly members of their families and close relations. It will therefore be protected as rigorously as other staff information and will be treated confidentially. Staff should be aware that any such register might be the subject of a Freedom of Information request. This would be dealt with in accordance with the Act, policy and appropriate guidelines.
Have you identified any training and / or resource implications as a result of implementing this? There are no training implications arising from this Policy and the Standards of Behaviour Framework. However, awareness of the importance of compliance with both documents will require reference

to them in induction programmes, during Individual Performance Reviews/Appraisals and at times when Employees are invited to make declarations.
Directors and Managers need to be aware of their responsibilities for advising staff that are accountable to them, of their responsibilities in connection with this Policy and the Code and ensuring declarations are made.

PTHB Values and Behaviours Framework
The Values and Behaviour Framework is for **all** staff working within the health board. The behaviours underpin the values that we, as an organisation, want to portray and as such they outline the behaviours in our interactions with colleagues, patients, public and service users, partners and stakeholders. Our values and behaviours are key to making Powys a "great place to work". They are the basis of all of our practices which will support a culture of continuous improvement and high performance.

1 Policy Statement / Introduction

The Standards of Behaviour Policy enables Powys Teaching Health Board (PTHB) to ensure that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out the expectations required and provides supporting guidance so that all employees and Independent Members are supported in delivering that requirement.

Public service values and associated behaviours are and must be at the heart of the NHS in Wales.

The Welsh Government's Citizen-Centered Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

The Board is strongly committed to the health board being value-driven, rooted in 'Nolan' principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The 'Seven Principles of Public Life' (the 'Nolan Principles'), form the basis of the health board's Standards of Behaviour requirements for its employees and Independent Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **Leadership** – Individuals should promote and support these principles by leadership and example.

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 reinforce the seven principles of public life and focus on the crucial public service values which must underpin the work of the health service; these are available via the following link: http://www.wales.nhs.uk/governance-emanual/codes-of-conduct

In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the seven principles of public life by:

- Ensuring that the interests of service users remain paramount;
- Being impartial and honest in the conduct of their official business;
- Using public funds to the best advantage of the service and the service users, always seeking to ensure value for money;
- Not abusing their official position for personal gain or to benefit family or friends;
- Not seeking advantage or to further private business or other interests in the course of their official duties; and
- Not seeking or knowingly accepting preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the health board.

This Standards of Behaviour Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the health board's Standing Orders. It re-emphasises the commitment of the health board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the health board, and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The policy is supported by a short guide on the Standards of Behaviour Framework (see **Appendix 1**) that provides a summary of expected conduct and is intended to complement all applicable professional codes of conduct, including:

- Nursing and Midwifery Council: https://www.nmc.org.uk/standards/code/
- Health and Care Professions Council: http://www.hcpc-uk.co.uk/
- NHS Consultants and General Practitioners: http://www.gmc-uk.org/guidance/index.asp

1.1	**Scope** This policy is applicable across the whole of the health board. It applies to all employees and Independent Members. The term 'employees' includes all those who have a contract of employment or honorary contract (including volunteers) with the health board, and

	bank workers. The policy also applies to trustees of the health board's Charitable Funds.
2. Aims and Objectives	
2.1	**Aims** PTHB is committed to ensuring that all employees and Independent Members practice the highest standards of conduct and behaviour, based on the recognition that the needs of service users must come first. The aim of this policy is to ensure that arrangements are in place to support employees and Independent Members to act in a manner that upholds the Standards of Behaviour Framework, as well as setting out the arrangements in place to manage declarations of interests, gifts, hospitality, honoraria and sponsorship, through the standard forms in place; these are accessible from the Forms Library on PTHB's intranet site via the link below: http://nww.powysthb.wales.nhs.uk/corporate-and-resource The policy also aims to capture public acceptability of behaviours of those working in the public sector in order that the health board can be seen to have exemplary practice in this regard. The purpose of this policy is to set out the organisation's expectations in relation to the standards of conduct expected of all employees and Independent Members and to provide guidance in order that all are supported in delivering these.
2.2	**Objectives** The objective of this policy is to clarify the relative responsibilities of employees and Independent Members in the discharging of this policy and adhering to the Standards of Behaviour Framework. The policy is designed to assist the health board and its employees and Independent Members in maintaining ethical standards in the conduct of NHS business. It sets out the principles the health board expects all employees to uphold, and the steps that the health board as an employer will take to safeguard the organisation where conflicts of interest arise. A conflict of interest can be defined as 'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering,

	commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.' A conflict of interest may be: • actual - a material conflict between one or more interests • potential/perceived – the possibility of a material conflict between one or more interests in the future All employees are expected to be familiar with the content of this policy, and line managers have a responsibility for bringing the policy to the attention of their staff.
3 Definitions • **PTHB** – Powys Teaching Health Board • **Staff/Employees** - This policy is applicable across the whole of the health board. It applies to all employees and Independent Members. The term 'employees' or 'staff' includes all those who have a contract of employment or honorary contract (including volunteers) with the health board, and bank workers. The policy also applies to trustees of the health board's Charitable Funds.	
4 Responsibilities	
4.1	**Chair** The Chair has the responsibility for performance managing the Independent Members of the health board through the annual individual performance review process on behalf of the Minister for Health and Social Services, and has the responsibility for holding the Chief Executive to account.
4.2	**Chief Executive** The Chief Executive is the 'Accountable Officer' with overall responsibility for ensuring that the health board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.
4.3	**Board Secretary** The Board Secretary has delegated responsibility for ensuring that the health board is provided with competent advice and support regarding the contents and application of this policy and the Standards of Behaviour Framework. The Board Secretary will ensure that: • A Register of Interests is established and maintained as a formal record of interests declared by employees and Independent

	Members. The Register will include details of directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS, and membership of professional committees and third sector bodies. Where relevant, it will also include details of interests of close family members (spouse, partner, civil partner, children, etc.). • Arrangements are in place to prompt all employees and Independent Members to complete a Declaration of Interests Form on initial employment with the health board, and at periodic intervals thereafter (N.B. It is the individual employee's or Independent Member's responsibility to make a declaration should their circumstances change within these timescales). • Scrutiny is applied to the declaration forms received to ensure appropriate declarations and acceptances have been made in compliance with the Standards of Behaviour Policy. • A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained. • The Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship are published on the health board's internet site in accordance with the requirements of the organisation's Freedom of Information Act Publication Scheme. • Reports detailing the content of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship, and the effectiveness and adequacy of the arrangements in place, are provided to the Audit, Risk and Assurance Committee on an annual basis. • The form that employees and Independent Members should complete when making a declaration of interest or when advising of gifts, hospitality, honoraria or sponsorship accepted or declined, is available on the health board's intranet site (http://nww.powysthb.wales.nhs.uk/corporate-and-resource).
4.4	**Executive and Assistant Directors** Executive and Assistant Directors must ensure that: • Employees are aware of the requirements contained within this policy and the Standards of Behaviour Framework. • They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality, honoraria or sponsorship. • Approve, or decline the acceptance of gifts, hospitality, honoraria and sponsorship that have been offered within their Directorate/Service **prior** to the event (and during periods of annual leave and prolonged absence, ensure that their responsibilities are delegated to their nominated deputy). • They review the contents of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship to assist with the verification of the accuracy of the information contained within it

	when alerted to do so by the Corporate Governance Manager on behalf of the Board Secretary. • They ensure any acceptances of gifts, hospitality, honoraria or sponsorship complies with the standards outlined within this policy.
4.5	**Departmental/Line Managers** Departmental/Line Managers will: • Ensure that this policy and the Standards of Behaviour Framework is brought to the attention of employees for whom they are responsible, and that they are aware of its implications for their work. • Actively seek declarations at regular intervals in respect of interests, secondary employment and gifts/hospitality from employees. This would include using opportunities such as discussions at Performance Appraisal Development Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews, as appropriate. • Support their employees in the application of the policy and the Standards of Behaviour Framework, seeking advice from the Corporate Governance Manager or Board Secretary, where necessary.
4.6	**Employees and Independent Members** All employees and Independent Members must ensure that they: • Understand this policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification. • Are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests that could potentially result in personal gain because of their position within the health board. • Declare to the health board for recording in the Register of Interests any relevant interests at the commencement of employment; whenever a new interest arises; or if asked to do so at periodic intervals by the health board. Relevant interests (including those of close family members or associates) may include: o Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs), with the exception of dormant companies; o Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the health board. This includes shareholdings, debentures or rights where the total nominal value is £50,000 or one hundredth of the total

nominal value of the issued share capital of the company or body, whichever is the less;
- Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
- A position of authority in a charity or voluntary body in the field of health and social care;
- Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests;
- Self-employment or employment by any other body. This includes the undertaking of agency working and private practice.
- Research funding / grants that may be received by an individual or their department.
- Any existing or new personal relationships which involve a professional colleague and which may give rise to an actual or potential conflict of interest, misuse of power or unfair bias.

- Inform service users and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a service user. The fact that the service user has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and Committee meetings, during procurement processes, and at other the health board / Directorate / Departmental meetings, as appropriate.
- Obtain permission from their Director / Assistant Director **prior to** accepting a gift, hospitality, honoraria or sponsorship which requires declaring and recording in the Register of Gifts, Hospitality, Honoraria and Sponsorship.
- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the health board.
- Where employees or Independent Members wish to engage in any outside employment, they must first discuss it with their Departmental/Line Manager. This will ensure that their position in the health board is not compromised. Agreement to such outside employment will not be unreasonably refused.

The onus regarding declaration will reside with the individual employee or Independent Member. It is recognised that a judgement may be required in individual circumstances regarding the appropriateness for a declaration to be made when, for example, there is a specific contractual situation, a set of circumstances, or series of specific circumstances or a close connection. Advice should be sought from the Corporate Governance Manager or the Board

	Secretary in this regard as such an interest may be deemed to be a potential conflict to the business of the health board. Where there is doubt, a declaration of interest should be made. It is also important that all volunteers adhere to health board policies and procedures, and this Standards of Behaviour policy is consistent with the Wales Council for Voluntary Action Code of Practice for organisations involving volunteers, available via the following link: https://www.wcva.org.uk/media/58792/wcva_volunteering_code_of_practice_a2_poster_4_final_proof.pdf
4.7	**Procurement Department** If an Employee is requested to participate in the procurement process they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared. If they have not previously completed a Declaration of Interest Form, they will be asked to do so before participating in the procurement process. The Procurement Lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest. The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise the health board, through the Corporate Governance Manager or the Board Secretary, of any such interests affecting health board services. Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of the health board, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff, for example, NHS staff benefits schemes. All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of the health board. Contracts may be awarded to such businesses where they are won in fair competition against other tenderers, but care must be taken to

	ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

5 Register of Interests

The Corporate Governance Manager, on behalf of the Board Secretary, will maintain the Register of Interests. This register will be made available on PTHB's internet site. (http://www.powysthb.wales.nhs.uk/lists-and-registers/)

A hard paper copy of the register, together with the forms that are used to inform their content, will be retained by the Corporate Governance Department.

6 Declarations of Interests at Meetings

It is a requirement that at the beginning of every PTHB Board, Committee or decision making meeting, members and those in attendance are invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the individual has a financial/pecuniary interest in the matter under discussion, the individual shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. Where necessary, at the discretion of the Chair, the individual may be ask to withdraw from the meeting itself until all business relating to the matter(s) in which they have declared an interest is concluded. The potential conflict and the action taken to avoid it will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict, the individual must declare their interest immediately.

Under certain circumstances, the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Board Secretary or the Corporate Governance Manager should always be sought prior to such a decision being made.

From time to time, employees and Independent Members may need to declare interests at other NHS organisations or partnership meetings. Such declarations will be recorded as if it were at the PTHB Board or Committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

7 Gifts and Hospitality, Honoraria and Sponsorship

Employees and Independent Members have a personal responsibility to volunteer information regarding offers of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined.

Employees should seek approval from their Executive/Assistant Director, prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on a Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) and submitted to the Corporate Governance Manager on behalf of the Board Secretary, for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality, honoraria or sponsorship should be accepted, the following principles should be considered:

- **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it;
- **Legitimate interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the health board i.e. further the aims of the organisation;
- **Relationship:** Consideration should be given as to whether the health board is likely to enter into a contractual relationship with the organisation / individual making the offer;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from offers that are more substantial. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation;
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct;
- **Reputation:** If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such, it should always be declined.

Employees must be impartial and honest in the conduct of business and remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to accept a bribe in his or her official capacity, or to corruptly show favour or disfavour in the handling of contracts or other business. Employees need to be aware that a breach of the provisions of this Bribery Act may render them liable to prosecution and disciplinary action.

The Bribery Act introduced a new criminal offence in 2011 where an individual or organisation offers or receives a bribe to bring about or reward the improper performance of a function or activity. Broadly, the Act defines bribery as 'Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.'

Bribery has the potential to impact upon an employees' or Independent Members' standard of behaviour, particularly in regard to the acceptance of gifts, hospitality, honoraria or sponsorship, although guidance on the Act indicates that only 'lavish' hospitality, or hospitality that is otherwise 'inappropriate' would normally fall under the bribery definition.

The Bribery Act also introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. This is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

However, an organisation can avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The provisions within this Standards of Behaviour Policy in terms of prohibiting the giving or acceptance of inappropriate gifts, hospitality, honoraria and sponsorship complies with the requirements of the Bribery Act and subsequent guidance.

Employees and Independent Members are therefore expected to:

- Report any issues relating to fraud, bribery or corruption to the Local Counter Fraud Specialist within the health board ;
- Declare any external interest which may result in the employee or persons known to the employee gaining direct or indirect financial advantage as a consequence of their work, which could influence any decisions made by the employee, or which could interfere with contractual obligations to the organisation;
- Ensure the interests of patients are paramount and that use or management of any public funds ensures value for money;
- Check each payslip as soon as possible following receipt to ensure that the amount paid is correct, with any queries raised with the line manager. If the employee believes that they have been overpaid, they must declare it immediately. Where employees do not understand their payslip, they should contact the Payroll Department.

The risks of breaching the Bribery Act include the following:

- Criminal justice sanctions against Board Members, Directors and other senior staff;
- Damage to the organisation's reputation;
- Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts;

- Potential diversion and/or loss of resources;
- Unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and
- Negative impact on patient/stakeholder perceptions.

Guidance regarding the types of gifts, hospitality, honoraria and sponsorship which may or may not be acceptable is provided below:

7.1	**Gifts** A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events/conferences. It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the health board. Such gifts should be refused and if they have already been received, they should be returned clearly advising why they cannot be accepted. The appropriate Executive/Assistant Director and the Corporate Governance Manager, on behalf of the Board Secretary, should be advised immediately. ***Any acceptance of a gift needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of a gift will not be misconstrued.*** N.B. This Standards of Behaviour Policy excludes gifts between members of staff, for example birthday presents or leaving gifts.
7.2	**Gifts from service Users or their Relatives** Personal gifts of cash from service users or their relatives are **not** acceptable. These may only be accepted as a donation to an appropriate Charitable Fund and recorded as such. PTHB's Head of Financial Services can provide advice regarding the mechanism for appropriately receipting such items in accordance with the Institute of Fundraising Code. Gifts up to the value of £25 may be accepted from service users and relatives as a mark of their appreciation e.g. for the care that has been provided. This does **not** include gift vouchers/ cards.

	A common sense approach should be applied to the valuing of gifts using an actual amount if known, or an estimate that any reasonable person would make as to its value. There is no requirement to declare such gifts up to this value, other than where several small gifts are received to the value of £25 from the same or closely related source in a 12-month period. Where gifts are provided to a group of staff, it is the responsibility of the Line Manager to declare the gift if over the value of £25. Where a gift is offered that is likely to be over £25 in value, it should be politely declined. In some cases, the gift may have already been made and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances, the gift can be accepted, and the bearer advised that it would be utilised for the benefit of Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) declaring that the gift has been received must be completed.
7.3	**Gifts from Suppliers, Contractors and Commercial Organisations** Low cost, branded or promotional gifts may be accepted where they are under the value of the common industry standard of £6 in total (selected with reference to existing industry guidance issued by the ABPI) and need not be declared. Any gifts outside this definition from suppliers, contractors and other commercial organisations doing business or likely to do business with the health board above this value, should be politely but firmly declined. Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined, a Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) should be completed to allow the health board to monitor when such organisations are inappropriately offering gifts or potential inducements. Under some circumstances, suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas or chocolates at Easter. Whilst such practices should be discouraged and whilst it is not acceptable for staff to personally accept these gifts, following discussion with the supplier / contractor / commercial organisation and the appropriate Executive / Assistant Director, it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds. The health board's Head of Financial

	Services can provide advice regarding the mechanism for appropriately receipting such items. Employees in contact with contractors should be on their guard against offers of gifts that might later be misconstrued as hampering their strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Corporate Governance Manager or Board Secretary, where appropriate.
7.4	**Gifts from Dignitaries/Overseas Organisations** There may be occasions when visits are made by dignitaries or overseas organisations who consider it 'culturally custom and practice' to exchange gifts. In such cases, employees should seek guidance from the Corporate Governance Manager or Board Secretary and declare these gifts on a Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource). A decision will then jointly be made as to the most appropriate way to manage the gift. This will depend on the nature of the 'gift culture' and may include decisions to 'keep and display in public', 'donate to an internal user group', 'auction for charity', etc.
7.5	**Bequests/Legacies/Wills** Employees are not permitted to accept bequests left to them by a deceased patient who became known to them through providing care or treatment as part of their health board employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an employee is made aware that they may be a beneficiary in a patient's will, they must declare this, with any complex cases escalated to the Corporate Governance Manager or the Board Secretary.

8 Hospitality

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours e.g. attendance at an awards ceremony, cheque presentations in respect of fundraising events, or tickets/seats for a show or sporting event.

Employees and Independent Members should refuse hospitality which may compromise or may be seen to compromise their professional judgement or integrity, or which seeks to exert influence to obtain a preferential consideration.

Employees in contact with contractors should be particularly mindful of accepting any offer of hospitality that might later be misconstrued as influencing strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Corporate Governance Manager or Board Secretary, where appropriate.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality will not be misconstrued.

Hospitality must be authorised by an Executive/Assistant Director prior to their acceptance and a Gifts, Hospitality, Sponsorship and Honoraria form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of members of staff to achieve the purpose of representing the organisation should attend.

Offers that go beyond modest, or are of a type that the organisation itself might not usually offer, need authorisation from an Executive/Assistant Director, and should only be accepted in exceptional circumstances, and must be declared.

For example, employees may receive an offer of payment for their travel and accommodation, when invited to speak at an event or attend a meeting. Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared on a Gifts, Hospitality, Sponsorship and Honoraria form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource). However, where business class or first class travel and accommodation (including domestic travel) or offers of foreign travel and accommodation are offered, a clear reason should be recorded on the declaration form as to why it is deemed permissible to accept travel and accommodation of this type.

8.1	**Acceptable Hospitality** Employees and Independent Members may accept the occasional offer of hospitality, provided that it is 'modest and proportionate' and similar in scale to that offered by the NHS. For example, acceptance of food and non-alcoholic refreshments during the working day will generally be deemed acceptable and need not be declared. Hospitality must be secondary to the purpose of a meeting. The level of hospitality offered must be appropriate and not out of proportion to

	the occasion; and the costs involved must not exceed the level that the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting. Other hospitality may be accepted where it furthers the aims of the health board, provided it is normal and reasonable in the circumstances, for example lunches in the course of working visits. Where the value is estimated to be over £25, a declaration should be made. Other hospitality that may be accepted but will need to be declared includes instances where: • There is a genuine need to impart information, or represent the organisation at stakeholder community events e.g. Local Authority or charitable organisations which have an association with the health board; • An employee has been invited to receive an award or prize in connection with the work of the organisation, or their role within it; • An employee is invited to a Society or Institute dinner or function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the health board. • An event is clearly part of the life of the stakeholder community or where the organisation should be seen to be represented; • A function or event is hosted for both staff and non-staff, which adds benefit and value to the health board or the wider NHS; • A function or event is hosted externally for staff only for the purposes of training or organisational development. These types of hospitality must be authorised prior to their acceptance by an Executive or Assistant Director and a Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of employees to achieve the purpose of representing the health board should attend.
8.2	**Unacceptable Hospitality** Unacceptable hospitality includes the following examples as general guidance: • A holiday or weekend/overnight break; • Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below);

- Use of a company flat or hotel suite;
- Attendance at a function or event restricted to employees which is not for the purposes of training or organisational development;
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event;
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories, advice should be sought from their line manager or the Corporate Governance Manager or Board Secretary.

Employees should report any case where they have felt pressurised into accepting an offer of hospitality that might be open to objection. They should also declare on the appropriate form any offers of hospitality that are declined.

9 Sponsorship

Sponsorship is an offer of funding to an individual, team or to the health board from an external source, whether in cash, goods, services or benefits.

Sponsorship is sometimes provided by organisations to allow employees to attend conferences. It may also include sponsorship of posts and research and development.

Employees may be offered sponsorship in the form of sponsored research, including publishing, an operational post, training, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

No sponsorship should be accepted without the prior agreement of the appropriate Executive or Assistant Director. A Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) should be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and/or declined, this should also be declared. In cases of doubt, advice from the Corporate Governance Manager or the Board Secretary should be sought.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

Some health related companies provide commercial sponsorship to the NHS, including sponsoring equipment, employees and training events. All employees must consider fully the implications of a proposed sponsorship deal before entering into any arrangement. Only very senior managers with the necessary authority can sign up to, or enter into, any advertising contract or agreement with a company or its representatives. Employees must not allow unauthorised advertising on health board premises or documentation.

More detail is provided below regarding the many forms that sponsorship may take. This list is not exhaustive and offers of other sponsorship will need to be considered on a case-by-case basis.

9.1	**Commercial Sponsorship for Attendance at Courses/Conferences** Employees may accept sponsorship for attendance at relevant conferences and courses, but only where attendance would further the aims of the health board and where the employee has obtained permission in advance from their Executive or Assistant Director and in line with the health board's Study Leave Policy. The sponsorship should only be extended to the number of employees who would have normally attended if funded by the health board. The employee and the Executive or Assistant Director must be satisfied that acceptance will not compromise purchasing or any future decision-making in any way.
9.2	**Commercial Sponsorship to attend Demonstrations/Technical Evaluations** Employees may be invited to view products or equipment at another location. There may be occasions, in-line with procurement standards, when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the health board will normally meet the costs of such a visit to protect the integrity of subsequent purchasing decisions. The appropriate Executive or Assistant Director following consideration of the implications for the integrity of subsequent purchasing decisions must approve arrangements whereby the company meets all or part of the cost of such a visit.
9.3	**Commercial Sponsorship – 'Linked Deals'** Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for the health board. PTHB will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the health board.

Linked deals must be approved and managed within an agreed process in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may 'linked deals' be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

Sponsored posts are posts that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive or Assistant Director.
- Rolling sponsorship of posts should be avoided unless appropriate checks are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest that cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Executive or Assistant Director should declare any posts sponsored by external organisations on a Gifts, Hospitality, Sponsorship and Honoraria form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) and submit it to the Corporate Governance Manager on behalf of the Board Secretary for recording on the register.

9.4 **Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations**

The pharmaceutical industry and allied commercial sector representatives may organise meetings, conferences or an activity in support of specific functions or specialties within the healthcare sector. Under such arrangements, they are permitted to fund the hiring of accommodation, meet any reasonable actual costs that may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link:.
http://www.pmcpa.org.uk/thecode/Pages/default.aspx

An example of hospitality that would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

Where the health board receives or invites offers of sponsorship for events that are hosted wholly or partly by the health board, the relevant Executive or Assistant Director must consider whether it is appropriate to accept the offer. For all offers, whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) must be completed and sent to the Corporate Governance Manager on behalf of the Board Secretary for recording on the register.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for the health board and the NHS.
- During dealings with sponsors, there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information that is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they

should not have a dominant influence over the content or the main purpose of the event.

- The involvement of a sponsor in an event should always be clearly identified.
- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and even-handed manner with opportunities being offered as widely as possible;
- Benefits should be for the health board (not an individual) and should be proportionate;
- Arrangements must not compromise the standing or image of the health board ;
- Sponsorship should be for a specific activity or event and not a general endorsement of the health board ;
- The sponsorship must not imply the health board endorses particular products, services or companies and organisations;
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices;
- Any arrangements that could bring adverse publicity to the event or the health board.

Particular care should be taken when considering sponsorship from companies or organisation for which the health board has, or could have, contractual business arrangements. The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit that may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile;
- To improve public / community relations;
- To generate public exposure and media coverage;

	• To differentiate the company from its competitors; • To increase profit/market share. Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in keeping with the principles listed above. Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party. Caution should be exercised in these circumstances, as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement. The health board may also receive unsolicited proposals for sponsorship that are not in response to any action that the health board has taken. The health board should carefully consider such offers and ensure that the proposal meets the health board's requirements, standards and principals. The health board will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest. All sponsorship arrangements should be approved by the appropriate Director or Assistant Director.
9.5	**Honoraria/Miscellaneous Payments** An honorarium is an ex gratia payment i.e. one which would not usually be expected to be provided. Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered. If this activity is to be undertaken during hours when the employee is contracted to work for the health board, the payment should be made to the health board. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. No payment or honoraria should be accepted without the prior agreement of the appropriate Executive or Assistant Director. A Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource) should be completed prior to the acceptance of any payment/honoraria.

N.B There are tax and national insurance contribution implications relating to honoraria that should be borne in mind as set out below:

- **Honoraria received for work undertaken during PTHB hours** - when appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contracted PTHB hours, any honoraria paid must be received back to the health board's revenue budget to reimburse the health board for the employee's time.

  To ensure good governance, the honoraria must be paid into a revenue budget that is **not** managed by the employee who has provided their services during health board time.

  To avoid personal tax implications, the employee is strongly advised to request the honoraria is paid directly to the health board. This is then seen as reimbursement to the health board to cover the loss of employee time, and not honoraria. This money will then be transferred into the health board's revenue budget. The employee who has undertaken the work must **not** be the budget holder for the budget receiving the funds in lieu of the honorarium to avoid any conflict of interest.

  Where the employee receives the honoraria directly and then reimburses the health board, the employee remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

- **Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)** - individuals are personally liable for the payment of both tax and NICs on any honoraria payments received for work undertaken in their own time.

  Where an employee wishes, a donation may be made to the health board's Charitable Funds in lieu of an honorarium. This must be received into the Charity's general fund. It is then for the Charity's trustees to determine how the donated funds should be used, with the principle being that the employee giving their own time should have no influence over how the donation is then used, to lessen the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

  In cases of doubt, employees should seek advice from the Corporate Governance Manager or the Board Secretary and should report any case where an offer of sponsorship or honoraria

	is pressed which might be open to objection. Instances where honoraria has been offered and declined should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource).

10 Use of the PTHB Logo

Permission needs to be obtained from the Corporate Governance Manager /Board Secretary or the Assistant Director of Communications and Engagement on all occasions where approaches are made by an outside organisation seeking to use the health board's logo in connection with an event or function. Any member of staff wishing to use the logo in connection with any non-health board related matter / event should also seek permission.

11 Research and Development

All research and development sponsored by commercial companies, including those sponsored by the pharmaceutical industry, must be approved by the appropriate mechanism, and governed by the specific policies and procedures. The Research and Development Department should be contacted in these circumstances to offer advice and support in this area.

12 Charitable Funds

There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way of funding attendances at courses or conferences. Monies paid into charitable funds from commercial companies must only be accepted as donations or for sponsorship. Where sponsorship is received, it should only be used to fund expenditure that is in line with the terms of the charitable fund's use. Such sponsorship should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form (http://nww.powysthb.wales.nhs.uk/corporate-and-resource).

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy; however there may be a close association. Further guidance is available from the health board's Head of Financial Services.

13 Secondary Employment and Private Practice

13.1	**Secondary Employment (Paid, Unpaid or Self-Employed)** PTHB's Secondary Employment Policy provides a framework for all employees who wish to undertake work for another employer alongside their PTHB role.

	Employees should inform their line manager of any secondary employment (this includes paid, unpaid or self-employment) and ensure that this does not affect their health board employment. Declarations should be made using the Declaration Form included in the Secondary Employment Policy. There should be no conflict with their normal contractual employment obligations to the health board, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with the health board. Failure to notify their line manager of secondary employment and/or private practice will invoke the health board's Disciplinary Policy. Where employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the health board. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment. Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the health board fulfils its statutory requirement of the Working Time Directive; this is available via the following link. http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm An employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity (including self-employment) during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. The manager in advance in all such cases must grant express written permission. An employee found to be undertaking other work during sickness absence without the prior written consent of the manager may be considered in breach of contract, and will be subject to disciplinary action that may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department.
13.2	**Private Practice** There are codes of practice in place relating to private patient practice that clearly include the fact that private practice should not adversely affect NHS duties.

Failure to notify their line manager of secondary employment and/or private practice will invoke the health board's Disciplinary Policy.

The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicates that no employee of the health board should work in a way detrimental to their health and performance.

For medical staff, the amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work; in that it sets out that an NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS.

Employees should:

- Seek prior approval before taking up private practice.
- Declare where they practice (name of private facility); what they practice (specialty, major procedures); when they practice (identified sessions/time commitment).
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.

14 Managing Personal Relationships

A personal relationship includes a business/commercial or financial relationship, as well as any relationship where a close family relationship exists, for example, including mother, father, daughter, son, sister, brother (and including step and in-laws) partner, ex-partner (including spouse or cohabiter), civil partner. This definition is not exhaustive and therefore anyone who considers that they may be in a potential conflict of interest situation should declare it. The scope of the term "personal relationship" also applies to prospective staff that have a relationship with a current member of PTHB's staff, or where a relationship starts during employment with PTHB.

Situations where a personal relationship may expose staff to conflict of interest or bias include, but are not restricted to, the following:

- Perceived or alleged breaches of probity (understanding the limits of authority and acting within those limits)
- Unfair advantage/favouritism
- Breach of confidence/confidentiality
- Harassment or bullying
- Employee relations issues
- Conflict of interest

- Any other issues perceived to be gained from the overlap of a personal and professional relationship.

In order to maintain the Health Board's integrity and reputation, it is necessary to acknowledge when personal and professional relationships overlap. It is recognised that there will be some relationships that may require an employee to withdraw from certain decisions or from undertaking certain duties to protect themselves and the Health Board from any conflict of interest, misuse of power or unfair bias. This applies to all members of the Health Board community including, but not exclusive to employees, Independent Board members, bank workers, agency workers, contractors and any third party engaged to work at the Health Board, including students on work placements, apprentices and volunteers.

- If employees have a professional or working relationship with someone that they consider to have a personal relationship with, they must ensure that their relationship with the individual does not impact, or appear to impact, the ability to perform their role. Where a personal relationship exists or develops between employees who are in a line management or supervisory relationship at work, they must avoid participating in decisions that might raise the appearance of a conflict such as recruitment and selection, allocation of funding, appraisal, disciplinary matters, sign off of expenses or in any other management activity or process involving the other party.

- Employees must declare any existing or new personal relationships they have which involves a professional colleague and which may give rise to an actual or potential conflict of interest, misuse of power or unfair bias. If the employee is unsure whether or not the personal relationship could give rise to an actual or potential conflict of interest, misuse of power or unfair bias situation, the employee should contact Workforce and OD in the first instance for advice and guidance.

- If employees undertake a role of Investigating Officer or Hearing Officer under Disciplinary Policy, Grievance Policy, Dignity at Work Policy and Safeguarding Procedure they should disclose that to a Workforce and OD representative.

- Any breaches to the disclosure of the personal relationship may result in disciplinary action being taken against the employee. Any behaviour that is considered inappropriate (i.e. evidence of unfair bias/personal conflicts brought into the workplace) will be investigated under the All Wales Disciplinary Policy.

15 Rewards for Initiative

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the health board receives any

rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into, before work is commissioned, or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain reward for their efforts, and the health board should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the health board should obtain a fair reward for the input its employees provide. If such an exercise involves additional work for an employee outside that paid for by the health board under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with the health board is the property of the health board and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights, is involved in decision-making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the health board is aware of this in order to manage it appropriately.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have

started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from the health board before entering into any agreement with bodies regarding product development, research, work on pathways, etc., where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.

Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

16 Social Networking Sites

All employees must uphold the reputation of the health board, and their professional body where appropriate, at all times. This means that conduct online and conduct outside of work should be judged in the same way, and should be of a similar high standard.

The All Wales Social Media Policy, accessible via the following link: http://www.wales.nhs.uk/sitesplus/documents/862/465-awsocialmediapolicy-v2.pdf sets out employee's responsibilities when using social media, and the implications involved. The term social media is used in reference to all Internet social networking and media sharing sites, such as Facebook, Twitter, YouTube, Snapchat, Instagram, Flickr etc., and to all 'blogs', 'chat', on-line commentaries, diaries, discussion forums, 'wikis' and sites allowing the posting of user generated content for mass consumption.

The policy is not intended to stop the use of social media, indeed the health board itself is making increased use of social networks to engage with patients, service users, staff and other stakeholders to deliver key messages, but rather to outline areas of best practice and illustrate where problems can arise for individuals and NHS Wales. It applies to the use of social media for business and personal purposes, both at work and outside of the work environment.

The health board acknowledges that everyone has a right to express himself or herself using social media, but also recognises its role in offering advice on the safe use of social media and highlighting the responsibility of employees to be aware of the potential consequences of posting content on to publically accessible platforms. The blurring of boundaries between an individual's private and professional life on social media is recognised and it is important that employees understand and are mindful that inappropriate use could damage both their and NHS Wales' reputation.

In terms of the business use of social media, local restrictions are in place to ensure that only those employees having a genuine business need are given access to organisational social media pages and can issue corporate or organisational statements and update content. Anyone wishing to develop a social media site or application on behalf of the organisation should speak to the health board's Communications Team in order for them to provide advice and guidance on the local approval process.

In terms of the personal use of social media, it is important for employees to understand their role as ambassadors for the health board, and to be conscious of the impact of their actions and words online, which may negatively affect the reputation and trust of the public.

The relationship with social media changes as soon as employees identify themselves or are identified as employees of NHS Wales or the health board. In these circumstances, they must make it clear that any views and opinions are personal and not necessarily those of the health board. As an NHS Wales employee, it is important to remember that expressing views or commenting on content on the internet in relation to the NHS cannot be divorced from one's working life, and any unguarded comments could bring the organisation into disrepute, and may also invite legal action against both the employee and the health board.

Where the health board uses public Wi-Fi, employees are encouraged to use their own personal devices to utilise any social media channels they wish to access.

However, personal use of social media should not be allowed to interfere with the performance of an employee's duties and any such access should occur during breaks or outside of normal working hours.

The health board reserves the right to monitor and log comments and references on social media sites, including those made by its employees, relating to itself, its employees, its services and the patients in its care.

Failure to adhere to the All Wales Social Media Policy may lead to disciplinary action up to and including dismissal, depending on the individual circumstances of the case.

17 Time Keeping

The time of employees is a health board resource in the same way as the buildings and equipment. The health board spends a significant amount of its funding on salaries and wages, therefore it is essential that it receive the full value for this expenditure. Where an employee is occasionally late for work or may have to leave early, this does not necessarily present an issue provided it is discussed with the line manager concerned. What is not

acceptable is where the employee falsifies time records to disguise absence or to claim attendance. Such action may constitute fraud, and will be dealt with in line with the Health Board's Disciplinary Policy and Counter Fraud Policy and Response Plan.

Employees must ensure that all time keeping records are accurately completed and if an inadvertent error is noticed, their line manager notified immediately. The types of records where care should be taken are:

- on-call registers
- additional duty hours claims
- annual leave records
- shift registers
- sickness records, including "self-certification"
- expense claims
- bank claim forms
- domiciliary visit claims
- clock cards
- flexi/time-in-lieu sheets

18 Election Campaigns

Welsh Government has produced guidance to NHS employees on their role and conduct during election campaigns.

The general principles that should be observed during the period of elections are that, as at other times, NHS staff should not engage in activities which could give rise to the criticism that individuals paid from public funds are being used for party political purposes, or which distract attention unduly to election campaigns.

The principles set out in this guidance apply to the NHS at all times, but particular note should be taken in the period between the start of formal campaigns and polling day.

All employees and Independent Members are requested to follow these guidelines:

- The NHS and its constituent bodies have no party political affiliation. Nothing should be said or done by any employee or Independent Member in their official capacity that suggests otherwise.
- NHS employees or Independent Members should not engage in activities which could give rise to the criticism that people paid from public funds are being used for party political purposes.
- No visits to Powys Teaching health board premises will be permitted by party political candidates and/or spokespeople for the purposes of personal canvassing. Party political meetings should not be held on NHS premises during the pre-election period.

- Political posters should not be displayed in public areas on NHS premises. Other posters and advertising material purporting to be apolitical and published by other groups should be carefully scrutinised to ensure that they cannot be regarded as favouring or opposing a particular candidate or party.
- Existing health promotion campaigns can continue, but new campaigns and all high profile publicity (large-scale mail drops, posters and advertising) should be deferred until after the elections.
- Social and electronic media has become more important to political parties and organisations during the pre-election period and staff should comply with existing guidance around its use both professionally and personally.
- All enquiries from political parties and candidates should be directed to the Chief Executive's Office and treated even-handedly.
- All media enquiries should be directed through the health board's Engagement and Communication Department on 01874 712489.
- Routine health board meetings that would normally be held in public may be held in the pre-election periods. Any public lectures given for educational purposes by the health board employees on health matters need not be cancelled or postponed, but should avoid debate or speculation on the outcome of the election and any impact that might have on government health policy.
- NHS employees are free, in their private capacity, to engage in public debate or comment during the election period. However, they should not use NHS premises or equipment and should not make comments based on information not generally available to the public. It must be clearly stated that the views expressed are those of the individual and not of the health board.

A full copy of Welsh Government's most recent guidance document on conduct during election campaigns (Welsh Health Circular 2016/002) is available via the following link: https://gov.wales/uk-general-election-2019-guidance-welsh-government-officials-whc2019035

19 Failure to adhere to Standards of Behaviour Policy

If any employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy or the Standards of Behaviour Framework, and then participates in a decision making process where special favour is shown to unfairly award a contract; or abuses their official position or knowledge for the purpose of benefit to themselves or their family or friends disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the health board's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within the health board. This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches the Standards of Behaviour Policy or Framework, this could in certain circumstances result in notification/reporting to the appropriate professional codes of conducts/registration/memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and employees no longer continuing to be employed in their current position within the health board.

Failure to declare a relevant interest by an Independent Member of the health board will be reported by the Chairman to the Minister for Health and Social Services.

20 Equality

The health board is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The health board has undertaken an Equality Impact Assessment to establish whether there are any possible or actual impacts that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was **no impact** to the equality groups mentioned above. Where appropriate, the health board will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

21 Resources

The implementation and management of the arrangements associated with this policy and the Standards of Behaviour Framework do not present any significant resource implications to the health board.

22 Training

All staff are required to comply with this Standards of Behaviour Policy. Whilst there are no particular training requirements or formal training programmes in place to ensure implementation of the policy, each Executive/Assistant Director and Service/Departmental Manager must ensure

that all employees are made aware of the policy provisions and that they are adhered to at all times.

Awareness of the importance of compliance with the policy will require reference to it in induction programmes, during Performance Appraisal Development Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when employees and Independent Members are invited to make declarations.

23 Implementation

The Register of Interests, and Gifts, Hospitality, Honoraria and Sponsorship will be maintained by the Corporate Governance Department. The Department will also be responsible for issuing periodic invitations to employees and Independent Members to declare interests, gifts, hospitality, honoraria and sponsorship.

To ensure that all employees and Independent Members are aware of their responsibilities concerning declaring interests, gifts, hospitality, honoraria and sponsorship, a number of communication methods will be utilised to raise awareness. This includes the use of team meetings, payslips, posters on wards targeted at patients and their visitors on how to make their gratitude known without offering gifts to staff, use of the staff intranet, and emails to remind employees and Independent Members of the Standards of Behaviour Policy, and their responsibility to comply with it.

Targeting of specific groups and forums will also be undertaken to raise awareness of the policy such as corporate and local induction, the Local Partnership Forum, and other key meetings such a one-to-one meetings.

Executive/Assistant Directors and Service/Departmental Managers will need to be aware of their responsibilities for advising employees accountable to them of their responsibilities in connection with the policy.

24 Publication of Registers

The Register of Interests and the Register of Gifts, Hospitality, Honoraria and Sponsorship will be published on the health board's internet site. An updated version will be added to the website quarterly. When making a declaration, employees and Independent Members are able to make representations that information on their interests or offers of gifts, hospitality, honoraria and sponsorship received, should not be published. This will allow for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publically available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

An interest will remain on the public register for a minimum of 6 months and no more than 12 months after the Corporate Governance Manager, on behalf

of the Board Secretary, has been informed that the interest has expired. A record of historic interests will be retained by the health board for a minimum of 6 years after the date on which it expired.

25 Audit and Monitoring

The Board Secretary is responsible for the monitoring of this policy and its formal review every three years.

The Board Secretary will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within the health board to be presented to the Audit, Risk and Assurance Committee at the end of each financial year.

The Audit, Risk and Assurance Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

The Wales Audit Office and Internal Audit may also review the arrangements in place from time to time with their findings reported to the Audit, Risk and Assurance Committee.

26 Distribution

The Standards of Behaviour Policy will be made available via the PTHB internet and intranet sites. Where employees do not have access to these sites, their line manager must ensure that they have access to a copy of this policy.

A reminder to all staff, together with a link to the policy will be circulated on a bi-annual basis to inform staff of the need to declare any interests and report offers of gifts, hospitality, honoraria and sponsorship.

Managers also have a responsibility to bring this policy to the attention of their staff. New members of staff will be made aware of this policy as part of the corporate induction process

27 Confidentiality

As set out in employees' job descriptions, all employees may have access to confidential information about patients, staff or health service business. On no account must such information be divulged to anyone who is not authorised to receive it. Confidentiality of information must be preserved at all times whether at or away from work. Any breach of such confidentiality is considered a serious disciplinary offence, which may be liable to dismissal and/or prosecution under current statutory legislation; Data Protection Act 2018, General Data Protection Regulation (EU 2016/679), or any subsequent legislation to the same effect) and the health board's Disciplinary Policy. Any

breach of confidentiality may lead to disciplinary action and may be regarded as gross misconduct justifying summary dismissal.

Where employees are unsure about the use or sharing of patient identifiable information, advice should be sought from the health board's Caldicott Guardian.

28 Please read in conjunction with:

Standing Orders & Standing Financial Instructions

- All Wales NHS Disciplinary Policy
- Confidentiality Policy
- Counter Fraud Policy & Response Plan
- Bribery Policy
- Secondary Employment Policy
- All Wales Procedure for NHS staff to Raise Concerns (AW document)
- All Wales Social Media Policy

29 Acknowledgements

This policy has been reviewed against the following Health Board / Trust policies across Wales:

- Abertawe Bro Morgannwg University Health Board - Standards of Business Conduct (to be reviewed November 2019)
- Aneurin Bevan University Health Board – Policy for Standards of Business Conduct (October 2015 – for review October 2018)
- Betsi Cadwaladr University Health Board - Standards of Business Conduct Policy (October 2016)
- Cardiff and Vale University Health Board - Standards of Behaviour Framework Policy (January 2015)
- Hywel Dda University Health Board - Standards of Behaviour Framework Policy (January 2015)
- Public Health Wales - Declarations of Interests, Gifts, Hospitality and Sponsorship Policy and Procedure (September 2017)
- Velindre NHS Trust - Standards of Behaviour Framework Policy (December 2015)
- Welsh Ambulance Services NHS Trust – Gifts, Hospitality, Interests, Commercial Sponsorship and Fundraising Policy (September 2018)

Appendix A - Standards of Behaviour Framework

The Board has established its Values and Behaviours Framework for **all** staff working within the health board. The behaviours underpin the values that we, as an organisation, want to portray and as such they outline the behaviours in our interactions with colleagues, patients, public and service users, partners and stakeholders. Our values and behaviours are key to making Powys a "great place to work". They are the basis of all of our practices which will support a culture of continuous improvement and high performance.

To support this, all employees and Independent Members must ensure that they carry out their roles with dedication and commitment to the health board and its core values.

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

- Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;

- Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
- Leadership – Individuals should promote and support these principles by leadership and example.

To uphold these principles you must: -

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

The Standards of Behaviour Policy outlines the arrangements within the health board to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

It is your responsibility to ensure that you are familiar with the requirements of the policy and supporting guidance. The relevance of this information will vary depending on your role within the health board and your interests outside of your employment.
In summary:

Do:

- Make sure that you are not in a position where your private interests and NHS duties may conflict.
- Declare any relevant interests. These include:
    a) Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs), with the exception of dormant companies;
    b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the health board. This includes shareholdings, debentures or rights where the total nominal value is £50,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;
    c) Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
    d) A position of authority in a charity or voluntary body in the field of health and social care;
    e) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests;
    f) Self-employment or employment by any other body. This includes the undertaking of agency working and private practice;
    g) Research funding / grants that may be received by an individual or their department;
    h) Any existing or new personal relationships which involve a professional colleague and which may give rise to an actual or potential conflict of interest, misuse of power or unfair bias.

If in doubt, declare it!

- Remember that the need to declare an interest also includes those of your close family and possibly friends.
- Seek your manager's permission before taking any outside work, including self-employment, in accordance with employment terms and conditions.
- Obtain your Executive/Assistant Directors permission before accepting any commercial sponsorship or hospitality;
- Declare offers of gifts, hospitality or sponsorship using the appropriate form where required.

Do not:

- Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;
- Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined;
- Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
- Abuse your position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favouritism in your dealings with commercial organisations;
- Use NHS resources for your own private use.

If you need any further guidance please contact the Corporate Governance Manager or the Board Secretary on 01874 712653.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2023/24								Updated: July 2023	
Position	**Name**	**Nature of Interest**	**Nature of Declaration**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**	**Last day in Powys Teaching Health Board**
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	13/04/2023	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2008	16th October 2022	Recently retired as CEO of Powys Association of Voluntary Organisations (PAVO)	Salaried Employment		
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Apr-18	Ongoing	Employee, Swansea University. (Manager of Community, Equalities & Chaplaincy, Student Services)	Salaried Employment		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	Apr-23	Current	Deputy Director Samaritans Powys	None	12/04/2023	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	NED of Green Inc Training Company Swindon	NIL	17/04/2023	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2022	Current	Chair of governors Neath Port talbot Group of Colleges Chair Confederal Governance UWTSD Member National Assembly for Wales Cross-Party Group on STEMM	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2020	Current	NPTC Group:Cross Party (Senedd) Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	06/04/2023	
		Spouse/Partner/Other	NIL		NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	£2668,80 p.a.net	24/04/2023	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Capital & Estates)	**Mark Taylor**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Aug-12	Current	Auster Counsulting Ltd	Non NHS	27/04/2023	
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Aug-12	Current	Wife Auster Consulting Ltd	Non NHS		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Aug-20	Current	Son - Final year of Pharmacy advanced qualification with CTMHB	NIL		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Not Known	Current	Brother in Law (John Young) Cognomie CEO	Not aware if operating in NHS Wales		
Independent Member (finance)	**Tony Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	28/04/2023	31-May-23
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	03/05/2023	

			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	05/05/2023	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2021	Current	Sister: Deputy CEO, The Advocacy Project, London	Salaried Employment		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	04/05/2023	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	NED IMPELO (dance organisation based in Powys)	None		
				Jun-21	Ongoing	Chair Cricket Wales	None		
				May-23	Ongoing	Cricket Director England and Wales Cricket Board	None		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Jul-22	Current	Chair of Brecon University Scolarship Fund	NIL	20/04/2023	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	May-22	Current	Elected Member of Powys CountyCouncil	NIL		
				Jun-05	Current	Elected Member of Brecon Town Countil • Chair of Finance Committee • Minor Authority school Governor (Priory Church of Wales)	NIL		
				2018	Current	Town Council GAP Member on the sustainable development Grant Committee with BBNPA	NIL		
				1984	Current	Member of the Labour Party • Brecon Branch Treasurer	NIL		
				1985	Current	Member of the Royal College of Nursing	NIL		
				1988	Current	A registered Nurse within the Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2003	Current	Owner of Celebratory Gifts/ Heraldic Names	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
EXECUTIVE MEMBERS									
Interim Chief Executive	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	05/04/2023	
		Spouse/Partner/Other	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Family member is the General Manager at Bronglais General Hospital, Hywel Dda University Health Board	Not Relevant		
Chief Executive (Secondment from 02.05.23)	**Carol Shillabeer**	Personal	Any other connection with a voluntary,statutory,charitabe or private body that could create a potential opportunity for conflicting interests	1990	Current	Member of the Royal College of Nursing	NIL	13/04/2023	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		

Director of Performance & Commissioning	**Stephen Powell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Jul-89	Current	Brother is a Paramedic within Welsh Ambulance Service NHS Trust.	NIL	19/04/2023
				Sep-08	Current	Sister is an ITU Nurse within Cardiff & Vale University Health Board.	NIL	
				Mar-20	Current	Wife is a Eating Disorders Nurse Specialist with Herefordshire & Worcestershire Health and Care NHS Trust.	NIL	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL	
Director of Finance and ICT and Primary Care	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL	20/04/2023
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	
Director of Therapies and Health Science	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	11/04/2023
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL	
Director of Nursing and Midwifery	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/06/2023
				1994	Current	Member of the Royal College of Midwifery		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL	
Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		22/06/2023
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL	
Director of Workforce and Organisational Development	**Debra Wood Lawson**	Personal	NIL	NIL	NIL	NIL	NIL	12/04/2023
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL	
Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Volunteer with Llanishen Cubs Association Member of Favulty of Public Health	NIL	26/04/2023
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL	
Interim Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	06/04/2023
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL	
Director of Corporate Governance	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	07/04/2023
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor - Newydd Housing Group Limited (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month	
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Sep-22	Current	Partner - National CAMHs Programme Lead for the NHS Wales Collaborative	Employed Position/ Salary	
				Jan-18	Sep-22	Programme Lead - Together for Children and Young People (NHS Wales Collaborative)	Employed Position/Salary	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Oct-22	Current (to Sept 2024)	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	

Date of Gift	Donor/Contact Name	Item Donated	Organisation	Channel received	Notes	Value likely to exceed £25	Accepted/Declined
12.04.2023	Next Step Nursing	Christmas Hamper:2 x Cadbury Variety Box 1 Cadbury Chocolate Box 1 Tin Roses 1 Tin miniture Heros 1 Box Wine Gums 1 Box Eclairs ! wicker basket	Next Step Nursing	Post	Posted to Bronllys Hospital, PTHB	Yes	Donated to Powys Health Charity
12.04.2024	Care Pro, 8-11 Clements Court, Clements Lane, Illford.IG1 1QZ	Christmas Hamper: Box Shortbread 1 Mini Jam Pot 2 x Mini Marmalade Pots 1 Box Lindor 1 Box Breakfast Tea 1 Bar Belgian Chocolate Truffle Traybake 1 box cheddar and Chilli Mini Bites 1 Bag Oak Smoked Chilli Crisps	Care Pro	Post	Posted to Bronllys Hospital, PTHB	Yes	Donated to Powys Health Charity
03.10.2023	Agency Pure HealthCare	1 gift box 7 bottles of wine Small box of Popcorn Chocolate	Agency Pure HealthCare	Post	Posted to Bronllys Hospital, PTHB	Yes	Donated to Powys Health Charity
20.10.2023	Gamma	Food and Hot Drinks/water Pens and Notepads	Gamma	In -Person (Supplier Day)	Hospitality and stationery accepted	Yes	Accepted
20.10.2023	Gamma	Tile brand tracking key ring	Gamma	In -Person (Supplier Day)	Key ring declined	estimated £20-£25	Declined
21.12.2023	Meridian Security System 67 New Roadside Horsforth Leeds Ls18 4JX	Chocolate Buttons Hot Chocolate Sachet 3 Biscuits Bar Chocolate Candle-Small	Meridian Security System	Post	Posted to Bronllys Hospital, PTHB	No	Accepted

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	✓						
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)				☒	☒	✓	
Governance	Review of Terms of Reference						✓	
Governance	Review of Standing Orders						✓	
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
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				✓		✓	
Finance and Procurement	Post payment Verification Workplan						✓	

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								