Audit Risk & Assurance Committee

Tue 08 July 2025, 10:00 - 13:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

Agenda_ARAC_ 08July2025.pdf (3 pages)

1.1. Welcome and Apologies

Verbal *Chair*

1.2. Declarations of Interest

Verbal and attached *All*

ARA_1.2_Board Members Declaration Of Interests summary 2025-26_June 2025.pdf (3 pages)

10:00 - 10:00
0 min

2. CONSENT AGENDA BUSINESS

Verbal *Chair*

The Chair will ask if there are any items from the Consent Agenda (item 7) that Committee Members wish to bring forward to the main agenda.

10:00 - 10:00
0 min

3. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

3.1. Minutes of the meeting held on the 17 June 2025

Attached *Chair*

ARA_3.1_DRAFT ARAC Minutes 17JUNE2025.pdf (8 pages)

3.2. Committee Action Log

Attached *Chair*

ARA_3.2_Action Log 2025-26.pdf (1 pages)

10:00 - 10:00
0 min

4. ESCALATED ITEMS

There are no items for inclusion within this section

10:00 - 10:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Internal Audit Progress Report 2025/2026

Attached *Head of Internal Audit*

ARA_5.1_Internal Audit Progress Report July 25 Cover Paper.pdf (2 pages)
ARA_5.1a_Internal Audit Progress Report July 25.pdf (10 pages)

5.2. Internal Audit Reports: Mattresses Final Report and Cancer Services Final Report

Attached *Head of Internal Audit*

ARA_5.2a_Mattresses Final Internal Audit Report.pdf (10 pages)

ARA_5.2b_Cancer Services Final Internal Audit Report.pdf (11 pages)

5.3. Confirmation of Clinical Audit Programme in place

Attached *Executive Medical Director*

ARA_5.3_Confirmation of Clinical Audit Programme.pdf (3 pages)
ARA_5.3a_AppA_Clinical Audit Programme 2025-26.pdf (20 pages)

5.4. External Audit Progress Report and Management Response

Attached *External Audit*

ARA_5.4_Audit Wales Update July 2025.pdf (12 pages)

5.5. Counter Fraud update & Reports

Attached *Head of Local Counter Fraud*

ARA_5.5_Counter Fraud Update Report Cover Paper.pdf (2 pages)
ARA_5.5a_Counter Fraud Update Report.pdf (3 pages)
ARA_5.5b_Appendix 1 - Briefing Report PTHB - Economic Crime and Corporate Transparency Act 2023.pdf (15 pages)
ARA_5.5c_Appendix 2 National Fraud Initiative Progress and Outcomes.pdf (6 pages)

5.6. Single Tender Waivers (including extensions to contracts)

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

ARA_5.6_Single Tender Waiver Report July 2025.pdf (3 pages)

5.7. Digital First Quarterly Monitoring (including Cyber Security)

Attached *Executive Director of Allied Health Professions, Health Sciences and Digital*

ARA_5.7_Digital First Assurance Report.pdf (31 pages)

5.8. Information Governance Toolkit (National Audit replaced Caldicott Principles)

Deferred *Executive Medical Director*

5.9. Assurance of Risk Management Arrangements

Attached *Director of Corporate Governance/Board Secretary*

ARA_5.9_Risk Management and Board Assurance Update_June 2025.pdf (12 pages)

5.10. Annual Corporate Governance Development plan

Attached *Director of Corporate Governance/Board Secretary*

ARA_5.10_ARAC Effectiveness Continous Improvement Plan 2025-26_Cover.pdf (6 pages)

10:00 - 10:00
0 min

6. ITEMS FOR DISCUSSION

There are no items for inclusion within this section

10:00 - 10:00
0 min

7. CONSENT AGENDA

7.1. Committee Work Programme

Attached *Director of Corporate Governance/Board Secretary*

ARA_7.1_2025-26 Committee work plans.pdf (1 pages)

7.2. Glossary

Attached *Director of Corporate Governance/Board Secretary*

ARA_7.2_Powys Teaching Health Board Glossary.pdf (5 pages)

7.3. Annual Review of Standing Orders

Attached *Director of Corporate Governance*

ARA_7.3_Annual Review of Standing Orders.pdf (2 pages)
ARA_7.3a_App1_2025.04.30 NHS SFI Procurement LHB PROCUREMENT AND CONTRACTING FINAL.pdf (19 pages)

10:00 - 10:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

Verbal *Chair*

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

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of next meeting: 07 October 2025 via Microsoft Teams

Verbal *Chair*

AUDIT, RISK AND ASSURANCE COMMITTEE

TUESDAY 08 JULY 2025
10:00-13:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest • Board Members Register of Interests	Verbal/ Attached	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
	3.1	Minutes of previous meeting held on 17 June 2025	Attached	Chair
	3.2	Committee action log	Attached	Chair
	4	**ESCALATED ITEMS**		
There are no items for inclusion within this section				
	5	**ITEMS FOR ASSURANCE**		
10:05 5mins	5.1	Internal Audit Progress Report 2025/2026	Attached	Head of Internal Audit
10:10 30min	5.2	Internal Audit Reports: • Mattresses Final Report (Limited Assurance) • Cancer Services Final Report (Reasonable Assurance)	Attached	Head of Internal Audit
10:40 10min	5.3	Confirmation of Clinical Audit Programme in place	Attached	Executive Medical Director
10:50 20min	5.4	External Audit Progress Report and Management response	Attached	External Audit
11:10 15min	5.5	Counter Fraud Update & Reports	Attached	Counter Fraud
11:25 5min	5.6	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/Director of Finance, Capital and Support Services
11.30 15min	**COMFORT BREAK (15mins)**			

11:45 20min	5.7	Digital First Quarterly Monitoring (including Cyber Security)	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital
12:05 15min	5.8	Information Governance Toolkit (National audit replaced Caldicott Principles)	*Deferred*	Executive Medical Director
12:20 15min	5.9	Assurance of Risk Management arrangements • Strategic Risk Register • Boad Assurance Framework (BAF) Dashboard	Attached	Director of Corporate Governance
12:35 5min	5.10	Annual Corporate Governance Development plan	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Committee Work Programme 2025/26 (For Information)	Attached	Director of Corporate Governance
	7.2	PTHB Glossary (For Information)	Attached	Director of Corporate Governance
	7.3	Model financial Instructions	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
12:40	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 07 October 2025 via Microsoft Teams		

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

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

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours

in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26								Updated: June 2025
Position	**Name**	**Interest Category**	**Interest Situation**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**
INDEPENDENT MEMBERS								
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	**Kirsty Williams**	Non Finanical personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025
		Non Finanical personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsiduary of Cardiff University	None	
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Finanical personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	**Steve Elliot**	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Partner-Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	**Simon Wright**	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	10/06/2025
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	

		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None	
		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL	
Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owneer:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party	NIL	
Independent Member (Capital)	**Michael Giannai**	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
Independent Member	**Ian Thomas**	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	NIL	09/04/2025
EXECUTIVE MEMBERS								
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025
		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery		
Executive Medical Director	**Kate Wright**	Non-Finanical professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025
		Non Financial professional Interests	Hospitality	19-Nov-24	20/11/2024	Attended digital conference which was funded by the hosting organiser (Health Strategy Forum).	An opportunity to meet with other NHS senior leaders and consider opportunities for use digital innovation in transforming Health care.	

Executive Director of People and Culture	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	29/05/2025
Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	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	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance / Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	My partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	My partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	£2,960 Per Annum	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board	Nil	

EXTRAORDINARY AUDIT, RISK AND ASSURANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 17 JUNE 2025 AT 10:30 VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ian Thomas	IT	Independent Member (General)
Kirsty Williams	KW	Independent Member (PTHB Vice Chair)
IN ATTENDANCE		
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Hywel Pullen	HP	Deputy Director of Finance
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Mike Jones	MJ	Audit Wales
Ali Tariq	AT	Audit Wales
Sarah Pritchard	SP	Head of Financial Services
Stella Gwynne	SG	Deputy Board Secretary
Hayley Thomas	HT	Chief Executive Officer
Carl Cooper	CC	PTHB Chair
Ian Virgil	IV	Head of Internal Audit
Anne Beegan	AB	Audit Wales
Bethan Powell	BP	Corporate Governance Officer
APOLOGIES FOR ABSENCE:		
Ronnie Alexander	RA	Independent Member (General)
Rhobert Lewis	RL	Independent Member (General)
Mick Giannasi	MG	Independent Member (Committee Vice Chair)
Louisa Steele	LS	Lead Local Counter Fraud Specialist
Matthew Evans	ME	Counter Fraud
Katie Blackburn	KB	Llais
Kirsten Jones	KJ	Llais

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/25/026)

The Chair welcomed everyone to the meeting, in particular those members who were in attendance as part of the new Committee Membership. Apologies for absence were received as recorded above.

1.2 DECLARATIONS OF INTEREST (ARA/25/027)

The Chair NOTED the attached Register of Interests and provided an opportunity for the declaration of any further interests pertaining to the meeting agenda.

HB highlighted a declaration on behalf of all Board and Executive Members in relation to the information provided within the Remuneration Report section of the Health Board's Annual Report 2024/25 (Item 5.5). The Committee NOTED the declaration.

2. CONSENT AGENDA BUSINESS (ARA/25/028)

No items were requested for inclusion in the main agenda.

3. ITEMS FOR APPROVAL/DECISION/RATIFICATION

3.1 MINUTES OF THE PREVIOUS MEETING HELD ON 13 MAY 2025 (ARA/25/029)

The minutes of the meeting held on 13 May 2025 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (ARA/25/030)

The Committee **RECEIVED** the action log which confirmed no live actions were present.

4 ESCALATED ITEMS

There were no items for inclusion within this section.

5 ITEMS FOR ASSURANCE

5.1 HOSTED BODY ANNUAL REPORT (ARA/25/031)

HB provided an overview of the Hosted Body Annual Report in absence of DWL. The presentation summarised that the Health Board hosts the Health and Care Research Wales support and Delivery centre. HB explained that an annual report to the Audit, Risk and Assurance Committee is required to provide assurance that both the Health Board as host, and the hosted body (HCRW) are fulfilling the requirements of the hosting agreement.

Independent Members sought assurance by asking the following questions:

How regularly is the relationship between the host and hosted body reviewed?
HB confirmed that it is a long-standing relationship, with the Hosted body reviewed on an annual basis.

Do Health Care Research Wales (HCRW) occupy PTHB estate premises, and can assurance be provided that Health and Safety issues are managed appropriately?
HB explained that HCRW are in the process of consolidating their estate on a regional basis. PTHB had provided support to HCRW to identify leased premises and procurement. Clarity around the number of estates premises occupied by HCRW would be shared with members at the next meeting.
Action: Director of Corporate Governance

Can assurance be sought in terms of lessons learned as a result of the potential fraud issues identified?

HB explained that the figures remained relatively low and confirmed were compliant with PTHB processes.

The Committee noted improved workforce metrics compliance in regard to mandatory training and PADR recording. SE commended the Health Board for its efforts as a result of this.

The Committee **RECEIVED** the Hosted Body Annual Report for Health and Care Research Wales and took **ASSURANCE** that the hosting agreement is being managed appropriately by both host and hosted body.

5.2 STRUCTURED ASSESSMENT REPORT 2024- MANAGEMENT RESPONSE (ARA/25/032)

HB provided an overview of the finalised Management response to the Structured Assessment report 2024 across all eight audit recommendations which would be monitored through via the Health Board's audit tracking process. HB welcomed the supportive relationship and constructive dialogue with Audit Wales in relation to the recommendations made.

Independent Members sought assurance by asking the following questions:

In relation to recommendation 4.2 'Ensuring a long-term strategy is in place post pandemic', what was the reasoning for no recommendations being accepted?
HB confirmed this was an administrative error and would be corrected prior to publication.

The Committee recognised the Health Board's relationship with the Regional Partnership Board (RPB), and the process to ensure the delivery of statutory requirements as a Health Board. Members discussed Powys' long-term strategy which has been developed in partnership with RPB and partners to deliver the area plan as part of national requirements. An update report would be presented to Committee in due course.

The Committee considered the need to explore a formal Memorandum of Understanding (MOU) arrangement with the RPB to strengthen governance and the process of responding to the Health Board. KW added that a discussion had taken place with the Lead Officer of the RPB in terms of strengthening governance and the need to explore a formal understanding of collaboration.
Action: Director of Corporate Governance

AB explained that Audit Wales were undertaking a separate review on Quality and Governance arrangements. A National review was being undertaken as a follow up on previous work around the Regional Care Fund. This would have a clear focus on governance and scrutiny of RPBs. Following completion of this work, a report would be presented to the Committee.

The Committee **RECEIVED** the Structured Assessment Report 2024 - Management Response and took **ASSURANCE** that appropriate management responses were in place.

5.3 INTERNAL AUDIT REPORTS 2024/2025 (ARA/25/033)

IV gave an overall view of the assurance obtained from the following Audits:

a) Quality and Safety Governance

b) Contract Management

a) Quality and Safety Governance

IV provide an overview of the report and confirmed a rating of Reasonable Assurance. Three medium priority findings had been found in relation to:

- Ensuring the structure and content of the Integrated Quality Report is continued to be updated to reflect evolving requirements
- inaccuracy of indicators and
- sufficient narrative to demonstrate quality is being improved.

Management had agreed to all three recommendations which would be implemented imminently.

KW recognised the helpful recommendations to improve quality and accessibility to track trends throughout the documentation.
The Committee RECEIVED and NOTED the report.

b) Contract Management

IV provided an overview of the report and confirmed that the report was advisory. The review had been undertaken further to the advisory review of Contracts and Procurement at Betsi Cadwaladr University Health Board (BCUHB), completed at the request of Welsh Government in 2023/24, which identified several areas of concern and non-compliance with BCUHB's Standing Financial Instructions (SFIs).

Six actions had been identified to take forward in partnership with other NHS Wales organisation to improve and/or enhance controls in contract management arrangements. This would be shared with the Committee upon completion and in collaboration with other NHS Wales organisations.

Independent Members sought assurance by asking the following questions:

For those individuals with a contract management responsibility, is it deemed appropriate throughout the NHS to undertake mandatory training and should Shared Servies lead this form of arrangement?
IV responded that formalising arrangements more centrally may be more appropriate and would provide feedback to Shared services on discussions.

The Committee **RECEIVED** and **NOTED** the advisory report.

5.4 FINAL HEAD OF INTERNAL AUDIT OPINION (ARA/35/034)

IV presented the Head of Internal Audit (HoIA) Opinion for 2024/25 and Annual Report and confirmed that the opinion provided the Health Board with Reasonable Assurance for 2024/25. The following summary of 2024/25 audits was provided and it was highlighted that two of the Audits remained at draft stage, the final iterations would be shared with members when complete:

- 7 Substantial Assurance

- 13 Reasonable Assurance
- 2 Limited Assurance
- 2 Advisory

The Report also included details of the 4 audits that have been removed from the plan during 2024/25, as previously reported to the Committee. These audits and the reason for their deferment had been considered when compiling the HoIA Opinion.

The HoIA Opinion would be reflected within the Health Board's Annual Governance Statement along with confirmation of action plans to address any issues raised. Particular focus would be included on the agreed response to the two Limited Assurance reports issued during the year.

Independent Members sought assurance by asking the following questions:

What actions had been undertaken to improve the Declaration of Liberty's (DoLs) given its rating of Limited Assurance?
HT confirmed that the Executive Committee had developed an action plan in response to the audit and an investigation case had been undertaken to agree to additional capacity to address the team's constraints. A report is due to be presented to the Patient Experience, Quality and Safety Committee in July to monitor the progress against the action plan. A follow up internal audit is also scheduled in 2025/26 to monitor progress, this would be shared with the Committee upon completion.

IV expressed his thanks to colleagues in the Health Board for their support throughout 2024/25. HB echoed thanks to Internal Audit for the work undertaken and welcomed the support and the collegiate relationship.

The Committee **CONSIDERED** and **NOTED** the Final Head of Internal Audit Opinion and Annual Report for 2024/25.

5.5 PTHB FINAL ACCOUNTABILITY REPORT AND FINANCIAL ACCOUNTS (LETTER OF REPRESENTATION) (ARA/25/035)

PH introduced the report and welcomed MJ who presented the overall findings and current position of the financial accounts. The following matters were highlighted for the Committee's attention:

- The £5M contingent liability invoice received from an NHS England provider had been escalated to Welsh Government and had subsequently been reviewed by Audit Wales's Audit Engagement Team, who had concluded that the matter should be treated as a contingent liability. Due to the value of the invoice, this matter was shared with Audit Wales's Head of Audit Services for peer review, the outcome of this review had yet to be confirmed, but early indications suggested that no further issues were anticipated. The final outcome of the peer review would be confirmed to the Board on 25 June 2025;
- Two errors had been identified in relation to Continuing Health Care accruals, these were not considered material. As a result of the identified errors

sample testing had been extended, for which the information had been provided but findings had yet to be confirmed. Should there be any changes to the materiality of the identified errors as a result of the extended testing this would be confirmed to the Board on 25 June 2025.
- Audit Wales indicated that due to the further work required in relation to Continuing Health Care accruals there could potentially be an impact on the approval of accounts timeline dependent on the findings of the extended sample testing. The Committee recognised the importance of delivery against the timeline, and it was agreed that any anticipated delays would be reported to the Board on 25 June 2025.

The Committee formally recognised the potential delay in the approval of the accounts timeline and **NOTED** the contingent liability in regard to the provider invoice acceptance.

HT raised the following matters for the Committees information:
- the importance of delivering the approved accounts in line with timescale was recognised;
- the contingent liability invoice regarding WVT had been escalated to Welsh Government, an update would be provided to members following receipt of response;
- thanks were expressed to Finance, Audit Wales and wider teams involved in the preparation of the accounts for the work undertaken.

Carl Cooper joined the meeting 11:24

The Committee **RECEIVED** and **NOTED** the financial accounts and the Chair and PH both expressed their thanks to the Finance and Audit Wales teams for the work undertaken.

HB noted that the Annual Report comprised of the three sections: the Financial Statements, the Performance Report and the Accountability Report. The Accountability Report had minor but not material amendments to be added prior to consideration by the Board on 25 June. These would be finalised imminently.

Committee Members sought assurance by asking the following questions:

Had consideration been given to the production of an easy-read version of the document for both staff and public and how is it communicated?
HB noted that the report is published in both English and Welsh through various Health Board channels and a summary version would be presented at the Annual General Meeting (AGM) in August which draws out elements around Performance, Quality and Finance.

Had any inconsistencies been discovered across the three reports?
MJ confirmed that no inconsistencies had been identified.

The Chair and Chief Executive both expressed thanks to the work undertaken by the Finance, Audit Wales, Internal Audit, Corporate Governance, People and Culture, Performance, Estates and others across the organisation in the production of the report

The Committee **NOTED** the content of the report;

- **NOTED** the accounts had been subject to a statutory audit by Audit Wales;
- **NOTED** the responses to enquiries of management and those charged with governance and;
- **RECOMMENDED** to the Board at its meeting on 25 June 2025 the approval and signature of the Annual Report and Financial Accounts for year ended 31 March 2026.

5.6 ENQUIRES OF MANAGEMENT AND THOSE CHARGED WITH GOVERNANCE (ARA/25/036)

PH presented the proposed response to the Audit Enquiries Letter 2024/25 for scrutiny and comments.
MJ confirmed that Audit Wales were content with the proposed response.

The Committee **NOTED** the proposed response.

5.7 RISK APPETITE (ARA/25/037)

HB provided an overview of the proposed revisions to the Board's Risk Appetite Statement as discussed at the meeting of the Board on 21 May 2025. The Board requested that the Audit, Risk and Assurance Committee discuss the proposals in relation to Financial Sustainability, to formulate a consensus and make a recommendation to the Board at its next meeting on 30 July 2025. The Board also recognised that there were differing opinions on the way in which the risk category of Financial Sustainability should be categorised in terms of appetite. The Committee recognised the importance of clarity within the statement to guide activity and the need to deliver the level of transformation required.

The Committee discussed the options of categorisation of both Cautious and Minimal given the significant challenges faced by the Health Board. It was felt that the Cautious category was not consistent with the Health Board's position and did not resonate the Health Board's direction. Members discussed the potential break down elements of the Financial Sustainability category to demonstrate more detailed considerations.

Members discussed a deconstructed approach which would split Financial Sustainability into three distinct categories: Financial Governance, Financial Sustainability and Financial Investment, recognising the impact on decision making. Members discussed the potential of creating complexity and cautioned against the creation of too many risk appetite categories and sub-categories.

It was noted that further work was required to integrate risk appetite centrally to support decision making. The Committee suggested that the Finance and Performance Committee should take a view of the approach given the ownership of Financial Sustainability risk. This would be shared with the Committee at its next meeting on 26 June 2025.

The Committee **RECEIVED** and **DISCUSSED** the proposed revisions to the Board's Risk Appetite Statement for financial sustainability.
Work would be undertaken to revise the categorisation of financial risks in line with the discussion held and an updated Risk Appetite Statement would be circulated to members electronically prior to recommendation to the Board in July 2025.

6. ITEMS FOR DISCUSSION
There were no items for inclusion in this section
7. CONSENT AGENDA
There were no items for inclusion in this section
8.OTHER MATTERS
8.1 ANY OTHER URGENT BUSINESS (ARA/25/038)
No other urgent business was raised.
8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/25/039)
It was **NOTED** that further work was required to clarify the categorisation of financial risks within the Risk Appetite Statement, and the proposed approach which be shared with the Finance and Performance Committee on 26 June 2025 prior to presentation of the revised Risk Appetite Statement for approval at the meeting of the Board in July 2025.
8.3 COMMITTEE REFLECTIONS (ARA/25/025)
The following feedback was noted: • Good debate around risk appetite • Gained an understanding of links between Committees and subgroups e.g. (RPB) • Purposeful and timely meeting • An induction for Audit, Risk and Assurance Committee members was due to be established in early Autumn to support the Committees new members in understanding their roles and responsibilities.
8.4 DATE OF NEXT MEETING
The date of the next meeting is scheduled on 08 July 2025 at 10:30 via Microsoft Teams.

Meeting closed at 11:57

Powell, Bethan
02/07/2025 21:48:39

Beth Powell

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- (08JULY 2025)								
OPEN ACTIONS - NOT YET DUE (08 JULY 2025)								
17-Jun-25	ARA/25/032	Director of Corporate Governance	Structured Assessment Report 2024	To explore a MoU arrnagement with RPB to strengthen governance and processes of responding to the health board	**01.07.2025 update:** the action will be progressed in line with the target date	Jan-26		On track
ACTIONS RECOMMENDED FOR CLOSURE (08 JULY 2025)								
17-Jun-25	ARA/25/031	Director of Corporate Governance	Hosted Body Annual Report	To clarify the number of PTHB estates buildings occupied by HCRW	**01.07.2025 Update:** The number is 0, however HCRW do have access to hot desks in the Brecon / Bronllys area but we do not formally occupy any buildings.			Completed

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

Agenda Item: 5.1

Audit, Risk and Assurance Committee	**08 July 2025**

Subject:	**Internal Audit Progress Report**
Approved and presented by:	Director of Corporate Governance / Board Secretary Head of Internal Audit
Prepared by:	Head of Internal Audit
Other Committees and meetings considered at:	N/A

PURPOSE:

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

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

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

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

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

The following two audits from the 2024/25 plan have been finalised since the June 25 meeting of the Committee:

- Cancer Services (Reasonable Assurance)
- Mattresses (Limited Assurance)

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

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 2025/26 plan was formally approved by the Audit, Risk and Assurance Committee at its March 25 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.

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
July 2025

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2025/26 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 2025/26 was agreed by the Audit, Risk & Assurance Committee in March 2025 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

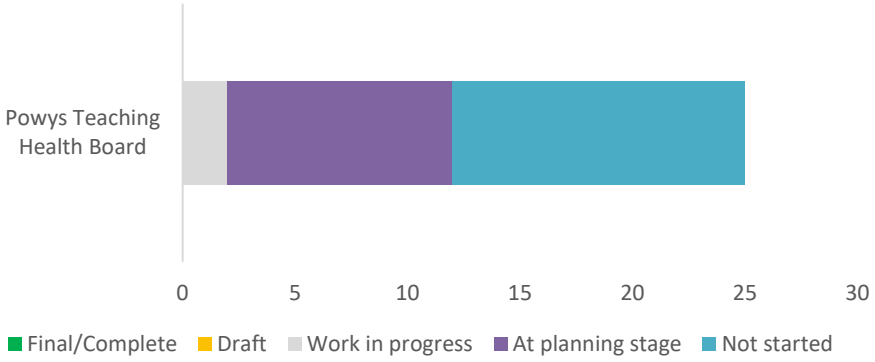
Two audit reports from the 2024/25 plan were not finalised in time for submission to the Audit Committee in June 25, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2024/25.

Both audits have now been finalised, as detailed in the table below along with the allocated assurance ratings. The full versions of the reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Cancer Services	Reasonable	
Mattresses	Limited	

3. Delivery of the 2025/26 Internal Audit Plan

There are a total of 25 reviews included within the 2025/26 Internal Audit Plan, and overall progress at this early stage of the year is summarised below.



The illustration shows that there are two audits that are currently work in progress with a further ten at the planning stage.

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

Appendix A also includes details of one further audit from the 2024/25 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2024/25. The outcome from that audit will feed into the 2025/26 Opinion.

4. Changes to the 2025/26 Plan

- Decontamination – The Director of Nursing, Quality, Women & Family Health has requested that the timing of this audit is moved from Quarter 1 to Quarter 3 due to a change in the Assistant Director and availability of the key management contact.

5. Assurance on Recommendation Tracking

The Health Board's Internal Audit Tracker provides the Committee with information on the current progress that has been made towards the implementation of outstanding Internal Audit actions. The information within the Tracker is based on responses provided by Health Board management confirming the current progress.

Each year we undertake a process of reviewing a sample of the entries within the tracker, in order to validate the stated position and provide additional assurance to the Committee.

Our audit sample focused on the 2023/24 actions reported as being complete to the Audit Risk and Assurance Committee through 2024/25. From a total of 32 High and Medium priority actions reported as complete, we selected 12 (37.5%) to form our sample. We then obtained evidence to establish if the actions were complete.

Sufficient information was identified as part of our testing to confirm that 11 of the 12 sampled actions had been correctly recorded as complete. We identified that one action from the Information Governance audit should have been recorded as partially complete. This has now been corrected within the tracker as part of the Follow-up audit.

The exercise has highlighted that the Committee can be reasonably assured that the progress information detailed within the Tracker for 2024/25 was accurate.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2024/25 Plan								
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.		Primary, Community Care and Mental Health	3		Planning		January
2025/26 Plan								
MH and LD Triage and Assessment Process	Review of the new Single Point of Access Triage and Assessment Model for Mental Health Services in PTHB. Linked to anticipated reduction in need for agency staff and impact on variable pay.	11	Primary, Community Care & Mental Health	1		Draft Brief Issued		October
Digital Systems Uptake	To review the level of uptake and utilisation of digital systems once they have been introduced. The review will include but is not limited to the Envoy system.	19	Allied Health Professions, Health Sciences & Digital	1		Work in Progress		October
Continuing Healthcare	Review of recent changes / future plans around CHC to address current level of cases and costs. Possible focus on the placement review process.	10	Primary, Community Care & Mental Health	2		Draft Brief Issued		October
Community Care	Review of how different teams within the community are working together for care of the patient.	12	Primary, Community Care & Mental Health	2		Planning		October
Follow-up DoLS	Follow-up of 2024/25 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	21	Nursing, Quality, Women & Family Health	2		Planning		October

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Duty of Candour	Review of the processes in place for management of concerns / complaints to ensure compliance with Putting Things Right regulations and the Duty of Candour.	22	Nursing, Quality, Women & Family Health	2		Work in Progress		October
Estates Assurance Asbestos Management	To evaluate the controls and practices in place to ensure that the key asbestos regulatory requirements are adequately addressed, and appropriate management arrangements were embedded within the organisation.	5	Finance, Capital & Support Services	2/3		Final Brief Issued		October
Strategic Commissioning	Review of the the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour.	14	Planning, Performance & Commissioning	2		Planning		January
Clinical Supervision	Establish the level of compliance with the Health Board's Clinical Supervision Policy across staffing groups. Focus on frequency / quality of supervision and quality of recording.	18	Allied Health Professions, Health Sciences & Digital	2		Planning		January
Staff Development Programmes	Review of the processes for developing and delivering staff development programmes, linked into Management Charter / Compassionate Leadership.	16	Primary, Community Care & Mental Health	2		Planning		January
Decontamination	Review of the Health Board's structures and processes for decontamination of equipment, to ensure compliance with standards and legal requirements.	23	Nursing, Quality, Women & Family Health	1	3	Final Brief Issued		January
Budget Setting	To review how the Health Board sets delegated budgets to meet its agreed financial plan.	03	Finance, Capital & Support Services	3				January
Core Financials	Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management / Accounts Receivable / Capital Asset Management.	04	Finance, Capital & Support Services	3				January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Systems – Discretionary Capital	To obtain assurance that appropriate controls are applied, and capital systems operate effectively in the allocation and delivery of the allocated discretionary capital funds.	06	Finance, Capital & Support Services	3				January
Primary Care Clusters – Project Management	How are the project management processes working to enable implementation of developments.	13	Primary, Community Care & Mental Health	3				January
Route Map to Sustainability	Advisory review of the plans and processes in place for the development of the Health Board's Route Map to Sustainability.	15	People, Culture & Transformation	3				January
Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	02	Corporate Governance / Board Secretary	3				March
North Powys Integrated Wellbeing Hub	To evaluate the processes and procedures put in place by to support the management and control arrangements applied to deliver the project through to the Submission of the FBC.	07	Finance, Capital & Support Services / People, Culture & Transformation	3				March
Catering Services	Review of processes and controls in place to ensure compliance with Environmental Health Office Standards / hygiene ratings.	09	Finance, Capital & Support Services	3				March
Digital Operating Model & Strategy	Review of the Health Board's new Digital Operating Model following previous Section 33 arrangements being brought in-house.	20	Allied Health Professions, Health Sciences & Digital	3				March
Mortality Reviews	Review of processes for dealing with deaths that are referred back to the Health Board by the medical examiner for further review.	24	Medical	3				March
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	08	Finance, Capital & Support Services	4				March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Vaccine Storage	Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.	25	Public Health	4				March
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	01	Corporate Governance / Board Secretary	4				May
Strategic Equality Plan	Review of delivery against the Health Board's Anti Racism Plan.	17	People, Culture & Transformation	4				May

Reviews removed from the plan

Assurance Opinions

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	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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Contact details

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Mattresses

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Limited Assurance

Contents

Review Reference	PTH-2425-20
Fieldwork	April - June 2024
Executive Sign Off	June 2025
Audit Committee	July 2025
Executive Lead	Claire Madsen, Executive Director of Allied Health Professions, Health Sciences & Digital
Audit Team	Ian Virgil, Head of Internal Audit
	Geoffrey Woolley, Principal Internal Auditor

Executive Summary

Purpose

The overall objective of the audit was to review the processes and controls in place across the Health Board to ensure that mattresses are subject to appropriate checks and maintenance.

All equipment that is used in the delivery of patient care possesses a potential infection risk directly to the patient utilising the equipment and a potential cross-infection risk if the equipment is not properly checked and decontaminated.

All Powys Health Board staff have a duty to safeguard patients and in doing so must ensure that equipment being used for patient care is appropriately decontaminated and checked to ensure its safe use.

The Health Board should prevent as far as reasonably practicable the risk of Healthcare Associated Infections to patients. The Health Board must therefore ensure that equipment, such as mattresses are appropriately checked and maintained to ensure they are fit for patient use.

Overview

We have concluded **limited** assurance on this area. The significant matters requiring management attention include:

- There is limited awareness of the Health Board's Mattress Policy and a lack of specific training provision for staff on the cleaning and assessment of mattresses;
- There is currently no process in place on the wards for confirming monthly compliance with the Health Board's policy on the cleaning of mattresses;
- Monthly mattress audits are not being consistently completed by all wards across the Health Board;
- No confirmation that actions are being taken to address issues identified through mattress audits;
- Completed mattress audits are retained on individual wards and not currently held centrally;
- Information was missing or incomplete within a number of the mattress audits reviewed; and
- There is no central monitoring or reporting arrangements in place for mattresses.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There are appropriate and up to date policies and / or procedures in place that set out the required processes for the cleaning, decontamination, maintenance and audit of mattresses.	-	**Substantial**
2	There is staff awareness and promotion of the policies / procedures and staff have undertaken / received appropriate levels of training.	1	**Limited**
3	Cleaning, decontamination and maintenance of mattresses is being undertaken in accordance with the stated policies / procedures.	2	**Reasonable**
4	Regular mattress audits are undertaken across the Health Board, with results reported and remedial action taken to address any issues identified.	3, 4, 5, 6	**Limited**
5	There are appropriate governance, monitoring and reporting arrangements in place for mattresses.	7	**Limited**

Management Actions

5	2
High Priority	Medium Priority

Themes

Risk Types

Quality or Safety Issues

Powell Bethan
02/07/2025 21:48:39

Findings & Agreed Action Plan

Objective 1: There are appropriate and up to date policies and / or procedures in place that set out the required processes for the cleaning, decontamination, maintenance and audit of mattresses.	**Substantial**

Overview / Summary of Observations

The Health Board Policy IPC 052 'Policy for the checking, replacement and auditing on mattresses, trolleys and cushions' (the "Policy") sets out the required processes for cleaning, decontamination, maintenance and audit of mattresses.

The Policy was issued in February 2024 with review due by February 2027. It was formally approved by the Infection Prevention and Control Committee in January 2024.

Objective 2: There is staff awareness and promotion of the policies / procedures and staff have undertaken / received appropriate levels of training.	**Limited**

Overview / Summary of Observations

The Health Board's Policy states that all employees should be familiar with it and understand their roles and responsibilities under it. Furthermore, it states that staff should receive appropriate training, which it expands as being mandatory training Infection Prevention and Control (IPC) level 1 and 2 as appropriate.

As part of the audit, we met with the two Community Services Managers (CSM), and staff from the following four sampled wards:

- Y Bannau ward – South Region;
- Adelina Patti ward – South Region;
- Brynheulog ward – North Region; and
- Maldwyn ward – North Region.

Our discussions with two CSMs and the ward staff indicates that while staff have general knowledge regarding how to clean and assess a mattress, most have limited, if any, awareness of the Policy.

In addition, our discussions indicated that whilst the relevant staff are shown how to carry out cleaning of mattresses, they do not receive any further specific training. We were also informed that IPC level 1 and 2 mandatory training only covers general Infection Prevention and Control issues, requirements and guidance and does not specifically address the cleaning of mattresses.

Furthermore, while the ESR system records all staff mandatory training undertaken, no register is maintained which records who has received specific training on the mattress policy and how this compares with those staff undertaking the work.

We were informed by the Professional Head of Nursing that training was provided to relevant staff between June 2023 and May 2024, around the time the Policy was introduced. However, no evidence was available to verify the training and the numbers of staff who received it.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of awareness and specific training on the Health Board's Mattress Policy.** Limited specific training on the Health Board's mattress policy has been provided and so most staff have limited awareness of its requirements. Furthermore, no register is maintained which records who has received specific training and how this compares with those staff undertaking the work.	Non-compliance with the policy requirements.	**Agreed Action:** Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered. **Expected Evidence of Implementation:** A mattress training register is in place which lists all staff undertaking work on mattresses and indicates when training was last completed.
		High Priority	**Officer:** Linzi Shone **Target Implementation Date:** 30/07/25
	Theme: Training & Development	Control Design	

Objective 3: Cleaning, decontamination and maintenance of mattresses is being undertaken in accordance with the stated policies / procedures.	**Reasonable**

Overview / Summary of Observations

We discussed the cleaning, decontamination and maintenance of mattress arrangements in place with staff in each of the four sampled wards. In summary, the following was noted:

- There was variation between wards in the staff who undertook the work, being domestic, healthcare assistant and nursing staff;
- Thorough deep cleans and checks were undertaken following patient discharge before arrival of the next patient; and
- Daily quick cleans and checks were undertaken with any issues quickly dealt with.

However, while these discussions confirm that staff have general knowledge regarding how to clean and assess a mattress, as noted under the previous objective, most staff have limited, if any, awareness of the Policy. Therefore, the activities undertaken may not fully comply with the detailed requirements set out in the Policy.

Key Findings		Risk & Impact	Agreed Management Action
2	**No monthly confirmation of compliance with the Health Board's policy.** There is currently no process in place whereby the ward leads confirm at the end of each month that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. There is also no periodic review undertaken by the CSMs to check completion and follow up on any issues where necessary.	Non-compliance with the policy requirements.	**Agreed Action:** A system will be implemented to record monthly confirmation from the ward leads that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. The records will be reviewed by the Community Services Managers and followed up where necessary. A summary of these declarations will also be incorporated into the reporting arrangements under Finding 7.
			Expected Evidence of Implementation: Records of monthly confirmations from each of the ward leads.
		Medium Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex
	Theme: Governance	Control Design	**Target Implementation Date:** 31/08/25

Objective 4: Regular mattress audits are undertaken across the Health Board, with results reported and remedial action taken to address any issues identified.	**Limited**

Overview / Summary of Observations

We requested the previous twelve months' mattress audits for each of the four wards in the North and four wards in the South regions. These had to be obtained from the individual wards are they are not available centrally on Teams or SharePoint.

We reviewed each of the mattress audits provided. In summary:

- There was a clear division between the two regions. In the North region, there was a generally good level of compliance with three wards having completed monthly audits for the whole period and one ward having completed monthly audits for two thirds of the time. However, in the South region there was a poor level of compliance with only a couple of monthly audits completed for two of the wards and no monthly audits for the other two wards.
- Multiple issues and areas for improvement were also identified following review of the audits that had been completed. These are detailed in the findings below.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Monthly mattress audits not completed by all wards.** As detailed above, monthly mattress audits are not being completed by all wards. Furthermore, the audit templates in the mattress policy were not consistently used.	Mattress issues may not be promptly identified.	**Agreed Action:** All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7.
			Expected Evidence of Implementation: Copies of completed monthly audits for all wards.
		High Priority	**Officer:** Linzi Shone
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 30/07/25
4	**Confirmation that actions are taken to address issues identified.** Where issues were identified in the mattress audits that we reviewed, there was generally no confirmation whether action had been taken to rectify the issues and if so, when it occurred. We also noted that there is currently no register in place that records the mattress audits and details any issues identified and the actions taken to address them.	Mattress issues may not be promptly rectified.	**Agreed Action:** A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary.
			Expected Evidence of Implementation:

			Copy of the mattress audit register with details of issues identified and actions taken included.
		High Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 30/07/25
	Theme: Reporting	Control Design	
5	**Retention of completed mattress audits.** Completed mattress audits are generally retained on the individual wards. They are not held centrally and are not therefore available for review or oversight. We were informed that a mattress audit Teams channel had been set-up but has not been fully implemented and is not therefore fully operational.	Mattress audits may not be readily available to everyone who need access to them.	**Agreed Action:** All mattress audits will be retained centrally, either on the Teams channel or SharePoint so that they are readily available to all staff who need access to them.
			Expected Evidence of Implementation: Copies of the mattress audits retained centrally on Teams or SharePoint.
		Medium Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 31/08/25
	Theme: Information, Data Quality & Data Accuracy	Control Design	
6	**Missing mattress audit information.** Mattress identifier numbers and identifiable signatures were often missing on the mattress audits we reviewed. On some of the audits we also noted that there was no information recorded for a number of the mattresses, and the reasons for the omissions were not indicated.	Incomplete mattress checks and inadequate traceability.	**Agreed Action:** Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.
			Expected Evidence of Implementation: Copies of audits with all required information included.
		High Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 30/08/25
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 5: There are appropriate governance, monitoring and reporting arrangements in place for mattresses.	**Limited**

Overview / Summary of Observations

Our discussions with the CSMs identified that mattresses are periodically discussed within some locality and ward meetings. For example, the North and Mid Powys ward managers meetings held in 2024/25 included discussions on mattress policy, replacement and auditing as part of the Governance and Assurance agenda.

However, regular central monitoring and reporting arrangements are not currently in place for mattresses.

	Key Findings	Risk & Impact	Agreed Management Action
7	**No central monitoring and reporting arrangements are in place.** As highlighted under the previous objectives, there is currently no central register of all mattresses in place, and no process for recording compliance with cleaning requirements or the completion of monthly mattress audits. As a result, there is also no central monitoring or reporting of information relating to mattresses. The information that should be captured and reported would be expected to include the following: • Details of all mattresses on each ward; • Confirmation of compliance with cleaning and maintenance requirements; • The number of mattress audits undertaken; • The number of issues identified analysed by category; and • The length of time taken to resolve the issues identified analysed into appropriate time bands. Furthermore, the report should include previously reported results so that comparison and trends can be identified and drawn out. This information should be regularly reported to appropriate Groups within the Localities and Service Group. There should also be a clear mechanism for escalating any serious issues identified through the reports up to an appropriate Committee of the Board.	Lack of corporate oversight.	**Agreed Action:** A system which captures the information suggested, will be put in place for mattresses along with appropriate reporting within the Localities. A clear mechanism for escalation of serious issues will also be established. **Expected Evidence of Implementation:** Copies of reports generated from the implemented system. Agendas and minutes from Locality and Service Group meetings confirming receipt and review of the repots.
		High Priority	**Officer:** Linzi Shone **Target Implementation Date:** 30/09/2026
	Theme: Governance	Control Design	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Cancer Services

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-2425-05
Fieldwork	April – May 2025
Executive Sign Off	Kate Wright, Executive Medical Director
Audit Committee	June 2025
Executive Lead	Kate Wright, Executive Medical Director
Audit Team	Ian Virgil, Head of Internal Audit
	Andrea Calise, Internal Audit Manager

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

Executive Summary

Purpose

The purpose of this audit was to review the effectiveness of the structure and processes in place to provide sustainable cancer services that deliver the suspected cancer pathway standards.

Limitation of scope

While the audit objectives include reference to arrangements involving external Welsh and English providers, the scope of our work was limited to the systems, processes, and governance arrangements in place within Powys Teaching Health Board. As such, the assurance provided through this review relates solely to the Health Board's oversight and commissioning arrangements, and not to the operational effectiveness or internal controls of the external providers themselves.

Overview

The Welsh Government's (WG) quality statement for cancer describes what good cancer services for Wales should look like. One of its most important features is the introduction of the Suspected Cancer Pathway (SCP), and the underpinning Nationally Optimised Pathways (NOP) for different cancer types.

The SCP was introduced in all health boards from June 2019 and is a Welsh Government target for diagnosing cancer and starting more timely treatment. The NOPs are a set of standardised care pathways for certain types of cancer. The nationally optimised pathways are 'timed' pathways of care that describe how organisations can achieve the NHS delivery framework target for the Suspected Cancer Pathway. The target for 2024/25 is that 75% of people on a SCP should start their first definitive treatment within 62 days of their point of suspicion. The target for 2025/26 is to work towards 80% by March 2026.

The Health Board provides key cancer outpatient and diagnostic services for a limited number of specialities and suspicion pathways and provides palliative care via DN and palliative care services. Majority of cancer services are commissioned from other Welsh and English providers and as part of A Healthier Wales Quadruple Aim 2, the Health Board has a responsibility to ensure appropriate provision for its residents who are receiving commissioned services.

Welsh Government issued a Welsh Health Circular in April 2024 providing guidelines relating to the management of patients on a Suspected Cancer Pathway (SCP) and the reporting of performance against the cancer target. The Health Board has adopted the Welsh Health Circular and developed an internal Standard Operating Procedure "Recording of Patients on Single Cancer Pathway (2024-2027)" guiding its staff on the administrative process for ensuring that patients are correctly added to and removed from the cancer tracker.

Compliance with the NHS Wales Suspected Cancer Pathway and English cancer targets for Powys residents is monitored and reported through the Integrated Quality and Performance Report (IQPR) under NHS Performance Measure 25.

We have concluded **reasonable** assurance on this area. The significant matters requiring management attention include:

- The Cancer Group, chaired by the Executive Medical Director, lacks formal governance, with no terms of reference, meeting minutes, or action logs in place. Its role and remit remain unclear, and meetings have been paused since December 2024 pending a review that has yet to be undertaken.
- While action logs are maintained and discussed at each Contract Quality and Performance Review meeting (CQPRM) with Welsh/English providers, the current documentation method of using separate Word documents, lacks consistency with unclear action numbering and missing target or revised completion dates.
- The Health Board is facing significant challenges in tracking cancer patients across Welsh and English providers due to fragmented IT systems, lack of shared patient identifiers, and reliance on delayed or pseudo-anonymised data. This limits real-time visibility, hinders care coordination, and impacts the Health Board's ability to oversee and properly challenge providers performance in relation to cancer services.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- The Long Term Agreement with Wye Valey trust has not been signed for 2024/25 due to ongoing financial disputes on the chargeable elements of the agreement. We note that service provision has not been impacted by this.
- We have identified concerns regarding the frequency and timeliness of the CQPRM with Wye Valley NHS Trust which could affect the timely oversight of quality and performance.

Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Clearly defined structures are in place, and these are operating effectively to oversee the delivery of Cancer Services, both by the Health Board and those which are being commissioned from Welsh and English providers.	-	**Substantial**
2	Governance arrangements are established which are appropriate and provide effective oversight of cancer services provided by the Health Board and commissioned from other providers, ensuring that they are subject to effective scrutiny and review.	1,2	**Reasonable**
3	Appropriate performance and improvement trajectories for cancer services exist with internal and externally agreed (Welsh and English providers) detailed actions plans where required.	3	**Reasonable**
4	Metrics to capture the performance of cancer services and the reporting of measures are in place and include the number of patients entering the Suspected Cancer Pathway.	3	**Reasonable**
5	Arrangements are in place for cancer data provision and interchange between the Health Board and Welsh/English providers that are timely, comprehensive, relevant and include data integrity/validation mechanisms.	3	**Limited**

Management Actions

1 High Priority

2 Medium Priority

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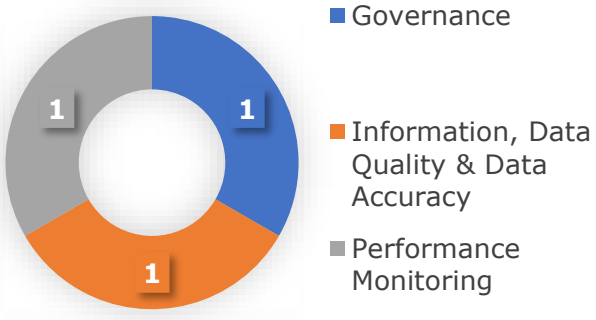
Themes



Risk Types

Choose an item.

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Choose an item.

Findings & Agreed Action Plan

Objective 1: Clearly defined structures are in place, and these are operating effectively to oversee the delivery of Cancer Services, both by the Health Board and those which are being commissioned from Welsh and English providers.	**Substantial**

Overview / Summary of Observations

The Health Board (HB) only provides limited cancer services and therefore does not have a dedicated cancer services team. We note that there is a single dedicated cancer administrator/cancer tracker post.

The Health Board relies on external providers for the majority of diagnostics and all treatment. Services are commissioned through Long Term Agreements (LTAs) and Service Level Agreements (SLAs) with various NHS Wales and NHS England providers. We note that at the time of our audit, the Health Board had not signed its 2024/25 LTA with Wye Valley Trust due to unresolved disagreements over the financial costings for service provision, including a significant dispute over high value invoice. We note that the Executive team is aware of these issues and that it has not had an impact on the quality and safety elements of the provision of services for Powys residents.

The commissioning and performance teams, oversee the monitoring of cancer services commissioned to Welsh and English Providers. The Senior Planned Care Manager manages the limited in-house cancer diagnostics activities for the Health Board (Endoscopy/bowel screening).

Strategic documents, including the Annual Plan 2025/26, emphasize cancer as a key priority. Standard Operating Procedures (SOPs) guide the administrative processes for managing cancer patients within the Health Board's WPAS system. The "Cancer Tracker" module within the Welsh Patient Administration System (WPAS) is crucial for recording and managing patient data.

Despite the challenges, including the absence of a dedicated cancer services team and reliance on external providers, the Health Board has an approach through its strategic focus and commissioning arrangements to provide assurance on comprehensive cancer care with the aim to improve patient outcomes.

Objective 2: Governance arrangements are established which are appropriate and provide effective oversight of cancer services provided by the Health Board and commissioned from other providers, ensuring that they are subject to effective scrutiny and review.	**Reasonable**

Overview / Summary of Observations

A review of the Health Board's governance arrangements for overseeing cancer service delivery identified the following key points:

- A Cancer Group, chaired by the Executive Medical Director and attended by cancer service key leads, meets on an informal basis. We note that the group has a decision-making remit however its structure, role, responsibility and alignment to the governance framework of the Health Board has not been formalised. We also note that the meetings are not minuted, and actions/decisions are not documented, highlighting the need for formalisation.
- Monthly Contracts Quality & Performance Review (CQPR) meetings with service providers (Welsh and English) take place and cancer performance is a standing agenda item for discussion. These meetings are a forum for the Health Board as the commissioner to engage with providers and hold them to account with respect to the terms and conditions of the long-term agreements in place. A review of the documentation in place for the CQPRM for our sampled providers (CTM and WVT) confirmed consistency in agenda templates but identified scope to improve the methodology for documenting decisions/action logs.
- Weekly planned care meetings and bi-monthly Endoscopy User & Audit Group meetings discuss operational escalations and risks impacting delivery (including cancer services).
- The Delivery and Performance Committee reviews cancer performance data bi-monthly, while engagement with Welsh Government and Welsh Cancer Network ensures alignment with directives and improvement plans. The Cancer Network, part of the NHS Executive for Wales, aims to enhance cancer care and outcomes across Wales. We note that the Health Board links into a number of cancer-related forums, including Cancer Site Groups (CSGs) for major tumour types. The Health Board's GP cancer lead chairs the national Upper Gastro-Intestinal CSG and co-chairs the primary care group. Although the Health Board does not routinely attend other CSGs due to not being a service provider, it remains virtually connected, with the GP Cancer Lead serving as the main contact for cancer-related updates and communications.

Overall, we feel that the governance mechanisms hold providers accountable for timeliness and harm mitigation, though influencing externally managed pathways remains difficult.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Formalisation of the Cancer Group** We understand that the Executive Medical Director chairs the Cancer Group. Throughout our fieldwork we were unable to determine the nature of the group, its alignment within the wider governance structure for the Health Board and its decision-making abilities.	Lack of clarity on the group's purpose, responsibilities, membership, and decision-making processes	**Agreed Action:** The purpose of the Cancer Group will be decided and whether it has been set up to operate as a Steering Group (Strategic oversight and focus) or a Task and Finish Group (task and objective based). Further to this, a Terms of Reference document will be documented and will be taken through the HB governance structure for scrutiny and sign off.

	The group meets on an ad-hoc basis and does not have an agreed and formalised Terms of Reference document. The meeting is not minuted and decisions made at the group are not documented within an action log. We also note that the group last met in December-24 with further meetings paused as the Group recognised that a review was needed on the purpose/remit of the group - we understand that this review is yet to be undertaken, and no further meetings have taken place (for now 6 months).		**Expected Evidence of Implementation:** Formalisation of the Cancer Group and development of Terms of Reference
		Medium Priority	**Officer:** Ruth Corbally - Cancer Lead
	Theme: Governance	Control Design	**Target Implementation Date:** August 2025
2	**Methodology for recording action logs arising from CQPRM** Whilst action logs are kept and are being discussed at every meeting, the current methodology for documenting actions could be improved. Currently actions are logged within individual documents for each meeting. We also note that the numbering format for actions is not traceable to the respective meeting it was raised, and target dates/re-vised target dates are not being populated.	Action items can be overlooked, responsibilities unclear, and progress stalled.	**Agreed Action:** The actions from CQPRM meetings will be documented by means of using a spreadsheet as opposed to individual word documents for each meeting. Also, target dates and revised target dates for completion of actions will be set in place.
			Expected Evidence of Implementation: Updated guidance and training material.
		Medium Priority	**Officer:** Chris Moss - Assistant Director of Performance and Commissioning
	Theme: Governance	Control Design	**Target Implementation Date:** August 2025

Objective 3: Appropriate performance and improvement trajectories for cancer services exist with internal and externally agreed (Welsh and English providers) detailed actions plans where required.	**Reasonable**

Overview / Summary of Observations

The HB's cancer service performance management operates at both Health Board and service area levels, with internal reporting focused primarily on Endoscopy and Bowel Screening Wales (BSW), the main diagnostic services delivered within Powys. Performance data is captured in the Integrated Quality & Performance Report (IQPR), which is shared with the Board and relevant committees.

Broader cancer pathway data, including diagnostics and treatment for Powys residents, is sourced from commissioned Welsh and English providers and discussed in regular meetings with Welsh Government (IQPD). We note that the Health Board has been experiencing issues and delays with the cancer performance data received from English providers (more in objective 5 and Finding 3)

A Cancer Improvement Plan, aligned with national priorities, was developed in 2023 and is under review for 2025/26 to reflect the new Quality Statement for Cancer. The Executive Team have been presented with the annual cancer improvement plan report for 2024/25 - this highlights the key successes and achievements against the plan for the year.

Commissioned provider performance and improvement actions are monitored through CQPR Meetings, though recent gaps in formal meetings have been noted (in Objective 2). While assurance is provided through reporting structures, we feel there is a perceived gap in operational oversight, that can be strengthened by agreeing and formalising the remit of the Cancer Group. We recommend that the Group take a more active monitoring role for this.

We note that the performance monitoring arrangements that are currently in place do not consider tumour sites pathway compliance/adherence with the National Optimal Pathways guidance.

The cancer performance of providers (Welsh and English) continues to be reviewed regularly and any learning for improvement of pathways is being shared. However, in spite of this, due to capacity constraints in commissioned services and wider national/systemic issues, the SCP performance is still challenged.

Objective 4: Metrics to capture the performance of cancer services and the reporting of measures are in place and include the number of patients entering the Suspected Cancer Pathway.	**Reasonable**

Overview / Summary of Observations

The Health Board is tracking a comprehensive and well-structured set of cancer performance metrics across multiple reporting layers, including operational dashboards, strategic oversight reports, and clinical governance forums.

Key strengths include robust monitoring of Single Cancer Pathway (SCP) compliance, diagnostic and treatment delays, downgrades within 28 days, and cross-border provider performance. We note that metrics and targets being tracked by the Health Board align with the NHS Wales Performance Framework 2024/25 and the Quadruple Aim model.

Analysis of the latest performance metrics (May-25) for the two sampled providers highlighted concerns with the service provision with CTM. The Health Board is well aware of the consistently poor SCP compliance and critical delays in colonoscopy access. These concerns are being addressed with CTM at the CQRPM, WVT's performance appears to be exceeding English averages however we note inconsistencies in the timeliness of data sharing (more in objective 5 and Finding 3).

There is a willingness to improve the integration of data from both Welsh and English providers, particularly Cwm Taf Morgannwg (CTM) and Wye Valley NHS Trust (WVT) however there are systemwide issues that are impacting this (more in objective 5). This is extremely important given the Health Board's unique commissioning landscape.

We feel that the Health Board has a robust escalation framework to ensure that the right metrics are being tracked and acted upon. Continued investment in data quality, digital integration, and patient-centred measures will further strengthen cancer service oversight.

Objective 5: Arrangements are in place for cancer data provision and interchange between the Health Board and Welsh/English providers that are timely, comprehensive, relevant and include data integrity/validation mechanisms.	**Limited**

Overview / Summary of Observations

The Health Board has established formal Long-Term Agreements (LTAs) with both Welsh and English providers that set out clear expectations for cancer data sharing. These agreements define the Health Board as the Data Controller and providers as Data Processors, in line with UK GDPR and the Data Protection Act 2018.

Both LTAs require monthly submission of patient-level Commissioning Data Sets (CDS), including NHS number, date of birth, GP, postcode, and gender, to support validation, performance monitoring, and reimbursement.

Governance arrangements include regular CQPR meetings and escalation mechanisms. Internally, the Health Board's Integrated Quality and Performance Report is submitted to the Board and Welsh Government, providing assurance on Single Cancer Pathway (SCP) performance.

A Cancer Group chaired by the Executive Medical Director has been set up to optimise collaboration and joint working within the Health board for cancer provision. As noted within objective 2, the remit of the group needs formalisation.

Despite these formal structures, a number of challenges have been identified:

- Inability to efficiently and effectively track transferred cancer pathways (Powys residents) across providers (Welsh and English).
- Lack of direct access to Powys residents' cancer pathway data residing with English providers.
- Delays in receiving timely cancer PTL (Patient Tracking List) data. From providers

We also note that the Health Board faces challenges in capturing and validating the point of suspicion for cancer patients, particularly when care is shared or transferred to other Welsh providers. These issues stem from inconsistent recording practices, lack of real-time data on open pathways, and absence of a unified tracking identifier. This may result in potential underrepresentation of Powys patients in SCP metrics and reduced ability to monitor early pathway performance.

Key Findings		Risk & Impact	Agreed Management Action
3	**Fragmented IT Infrastructure for national cancer services performance** Despite formal agreements and governance structures, the Health Board faces several challenges in tracking cancer patients (Powys residents) across providers (English and Welsh). The majority of issues are outside the Health Board's control and relate to the national IT infrastructure in place: • There is no shared SCP Pathway Identifier, making it difficult to follow patients transferred between providers. • Commissioning performance Data from English providers is centrally held by the Commissioning service Unit and is provided to the Health Board Monthly. However, we note that the data is pseudo-anonymised and cannot be traced back to individual patients. • The HB often receives information only after treatment has commenced. Attempts to access NHS England's central data warehouse have been made by the Digital and Performance team however these have not resulted in a solution. Currently there is reliance on manual data feeds from individual English trusts which introduces inconsistency and administrative burden. There is a lack of clarity and consistency in recording the point of suspicion dates by Welsh providers. This is critical because the point of suspicion is the official start of the SCP clock and directly impacts performance metrics and patient tracking. There are also operational delays in diagnostics and histology commissioned services. Delays in reporting which can leave patients in a suspected status but still open on the WPAS system, awaiting confirmation. This affects the ability to close/downgrade pathways and accurately reflect the point of suspicion and subsequently meet the milestones against the SCP targets. We note that this is an intentional approach put in place by the Health Board where pathways are not downgraded until consultants provide confirmation preventing pathway closure by accident.	Lack of clarity on the group's purpose, responsibilities, membership, and decision-making processes	**Agreed Action:** The Health Board will continue to advocate, engage and work with providers and with DHCW/NHS Wales and NHS England to attempt to improve the current state of IT Infrastructure surrounding national cancer performance data. **Expected Evidence of Implementation:** Copies of communications and notes of meetings demonstrating continued engagement and advocacy with providers and with DHCW/NHS Wales and NHS England
	Theme: Information, Data Quality & Data Accuracy	**High Priority** Control Design	**Officer:** Chris Moss - Assistant Director of Performance and Commissioning and Simon Mclellan - Head of Performance **Target Implementation Date:** March 2026

Appendix B

Assurance Opinion

Substantial

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

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.3

Audit, Risk and Assurance Committee	**Date of Meeting: 08 July 2025**
Subject:	Confirmation of Clinical Audit Programme
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Director of Corporate Governance/Board Secretary
Other Committees and meetings considered at:	Patient, Experience Quality and Safety Committee – 29 April 2025

PURPOSE:

The Audit and Risk Assurance Committee is required, under its Terms of Reference to ensure that a Clinical Audit programme is in place for the Health Board. This paper presents the Committee with confirmation of the PTHB Clinical Audit Programme 2025/26 (Appendix A).

The Patient Experience, Quality and Safety Committee considered and approved the plan at its last meeting on the 29 April 2025. The plan is attached as **Appendix A.**

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE** that the Health Board has in place a Clinical Audit Plan, which is overseen by the Patient Experience, Quality and Safety Committee.

Approve/Take Assurance	Discuss	Note
Y		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING 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		

BACKGROUND

Clinical Audit, the systematic review of actual performance against expected standards, remains an important benchmarking tool in determining the level of our clinical standards and is an important tool in guiding continuous quality improvement.

It will provide assurance in areas where procedures are inherently high-risk, or where new processes and policies have been introduced. It may also identify areas of concern where the significant input of resources may be required.

A Clinical Audit Plan has been drafted for 2025/26 which incorporates the following:

- High volume basic activities which require a high level of compliance.
- Concerns identified during investigations of Nationally Reportable Incidents or complaints.
- New policies or changes to existing policy / practice to confirm new practice is established.
- The prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- Clinical audits required to confirm that practice has improved where concern had been raised.

The plan was developed and approved by the Assistant Directors with responsibility for;

- Women and Children's Services
- Community Services Group
- Mental Health and Learning Disabilities Group
- Medicines management
- Primary Care

A copy of the current Clinical audit Plan 2025/26 can be found in Appendix A.

National Clinical Audit Programme

The National Clinical Audit Programme is a programme of audits commissioned by the London-based Healthcare Quality Improvement Partnership (HQIP) on behalf of the UK Department of Health.

Any national audits that are continuing as part of a multi-year audit plan are included in this program and any others will be added to the Clinical Audit program once known.

Progress against the Clinical Audit Plan will be reported within agreed timeframes to PEQ&S. This will highlight:

- Any significant actions to be taken from needs identified in the audits.
- The sharing of appropriate learning across services.
- The sustainable implementation of any safety improvements made.

New developments for 2025/26.

Introduction of the Medical e-Governance (MEG) Clinical audit software
The MEG Clinical audit software is currently used to record data in support of a number of infection control audits.

Audit of the completion of Do Not Attempt Cardio-Pulmonary Resuscitation forms
The appointment of a full-time Resuscitation Officer means that Powys will undertake an audit of the completion of DNACPR forms in accordance with the latest All-Wales resuscitation policy.

The Powys Audit Hour
The Powys Audit hour, a forum for presenting clinical audits and sharing of learning was successfully introduced last year. This will be further developed over the coming year.

Community Services Group

Surgery and Endoscopy

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Staff Survey	Annual	Theatre and Endoscopy	Theatre / Endoscopy Lead	Quarter 4
Service Evaluation	Hand hygiene Audits	Monthly	Theatre and Endoscopy	Theatre / Endoscopy Lead	Quarter 4
Service Evaluation	Legal and ethical audit	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Data protection and GDPR	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Management/Human Resources	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Education	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Five Steps to Safer Surgery	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Managing Perioperative Normothermia	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Medical devices audit	Bi yearly	Theatre	Theatre Lead	Quarter 1 Quarter 4

Service Evaluation	Risk Management (Organisational and Environmental)	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Decontamination	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Specimen Management	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Tourniquets	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Use and Handling of Surgical Instruments	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Preoperative care for Patients with Dementia	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Anaesthesia	Annual	Theatre	Theatre Lead	Quarter 3
Local Audits for Service Improvement	Surgical record keeping audit & consent	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Post anaesthetic Care	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Electrosurgery	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Fluid Management	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Surgical patient story	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Pre assessment and Specific Day Case Requirements	Annual	Theatre	Theatre Lead	Quarter 4

Service Evaluation	Audit of prosthesis verification data	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Intraoperative Care	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Infection Control	Annual	Theatre	IPC	Quarter 4
Service Evaluation	NEWS audit	Annual	Theatre	Quality & safety lead Clinician/Planned care manager	Quarter 4
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Annual	Theatre	Planned care manager	Quarter 4
Service Evaluation	Individual endoscopists KPIs	6 monthly	Endoscopy	Endoscopy Clinical Lead	Quarter 1 Quarter 3
Service Evaluation	Electrosurgery	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Fluid Management	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Surgical patient story	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Pre assessment and Specific Day Case Requirements	Annual	Theatre	Theatre Lead	Quarter 4

Service Evaluation	Audit of prosthesis verification data	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Intraoperative Care	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Quarter 4
Service Evaluation	Post colonoscopy colorectal cancer rate	As and when reported	Endoscopy	Endoscopy Clinical lead	Quarter 4
Service Evaluation	Patient satisfaction survey	Annual	Endoscopy	Data/ Audit Support	Quarter 4
Service Evaluation	Patient story	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 3
Service Evaluation	Endoscopist satisfaction survey	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Service Evaluation	Vetting and validation of endoscopy referrals	Annual	Endoscopy	Clinical lead Endoscopy	Quarter 4
Service Evaluation	Environmental audit Process Improvement Tool (PIT) Llandrindod Wells /Brecon	Annual	Endoscopy	Infection Prevention and Control	Quarter 2
Service Evaluation	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2

					Quarter 4
Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Annual	Endoscopy	Bowel Screening Wales	Quarter 4
Local Audits for Service Improvement	Record Keeping/Consent	Annual	Endoscopy	Endoscopy Coordinator	Quarter 3
Service Evaluation	Annual planning & productivity report	Annual	Endoscopy	Planned Care Manager	Quarter 3
Service Evaluation	Scope traceability	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement	Inclusion/exclusion criteria audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement	Bowel Screening Wales pathology reporting audit	Annual	Endoscopy	Business Support Manager Planned Care	Quarter 3
Local Audits for Service Improvement	Pain / Comfort Audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement	Single cancer pathway process	Annual	Endoscopy	Planned care manager	Quarter 4

Local Audits for Service Improvement	Audit of open access referrals into our service	Annual	Endoscopy	Planned care manager	Quarter 4
Local Audits for Service Improvement	Audit for Endoscopy Screening assessment	Annual	Endoscopy	Planned care manager	Quarter 4
Service Evaluation	Medical devices audit	Bi yearly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 4

Therapies and Health Science					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Pregnancy Status	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 1	Radiography	Head of Radiography	Quarter 3

Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Reject analysis	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 1	Radiography	Head of Radiography	Quarter 3
Local Audits for Service Improvement	QA reporting Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 1	Radiography	Clinical Governance Lead for Sonography	
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Other National Audit & Service Evaluation	The Sentinel Stroke National Audit Programme	Quarter 1 - Monthly	All AHPs	Consultant Therapist for Stroke	Quarter 4

Audits performed for accreditation schemes	Red Dot	Quarter 3	Radiography	Head of Radiography	Quarter 4
Local Audits for service improvement	Therapy Outcome Measures Audit	Quarter 1	Speech and Language Therapy	Head of Speech and Language Therapy	Quarter 4
Local Audits for service improvement	Correct use of radiographic markers	Quarter 4	Radiography	Head of Radiography	Quarter 4
Local Audits for service improvement	MIU NMR Audit for appropriate referrals	Quarter 4	Radiography	Head of Radiography	Quarter 1
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	TBC National
Other National Audits	SNAPP	TBC National	Therapies & Health Sciences	Consultant Therapist - Stroke	TBC National
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	TBC National
Other National Audits	Adult Audiology Standards	TBC National	Audiology	Professional Head of Audiology	TBC National
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 1	OT	Professional Head of OT	Quarter 4

Service Evaluation	MSK Transformation Business Case	Quarter 4	Physio	Professional Head of Physio / Consultant MSK	Quarter 1

Community Dentistry					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement	Patient Experience Audit	April 2025	Community Dentistry	Tesni Jones	May 2025
Other National Audit	WHTM01-05	July 2025	Community Dentistry	Rachael Anwyl	Sept 2025
Local Audits for Service Improvement	Written Consent to treatment audit	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Dec 2025
Local Audits for Service Improvement	Compliance with Acorn and Fluoride Application for GDS patients	Sept 25	Community Dentistry	Evelyn Gough	Sept 2025
Local Audits for Service Improvement	Antimicrobial Stewardship	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Jan 2026
Local Audits for Service Improvement	Patient engagement and outcomes of treatment visits	Jan 2026	Community Dentistry	TBC	Feb 2026
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of	Continuous yearly run chart	Community Dentistry	Warren Tolley/ Catherine Adams	Continuous yearly run chart

	dental radiographs in the Community Dental Service				

Unscheduled Care (updated Feb 2025)					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement	Missed Fractures Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Mattress audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Hand Hygiene Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Primary Care Attenders – removed as reported in BI	Biennial 2023	Unscheduled Care	Senior Manager	
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit – Removed as reported in BI	Biennial 2023	Unscheduled Care	Senior Manager	
Local Audits for Service Improvement	PGD Audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Biennial 2024	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Ask & Act – Audit tool for RE Enquiry for Domestic Abuse in MIU	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025

Medical Directorate					
Medicines Management					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement	**4C antimicrobial prescribing in primary care.**	Quarter 2 2025/26	The Antimicrobial Stewardship (AMS) Pharmacist recruited October 2024 will take the lead on this audit moving forward.	Chief Pharmacist Emlyn Pritchard/Amie Bain	Quarter 3 2025/26
Local Audits for Service Improvement	**"Start Smart then Focus"** audit for antimicrobial prescribing in community hospitals	Quarter 1 2025/6		Amie Bain	Quarter 4 2025/6
Local Audits for Service Improvement	**Community Pharmacy Rota Services** The aim of this audit is to establish how much current rota services are used for their intended purpose.	Quarter 2 2025/26		Chief Pharmacist Emlyn Pritchard/Gail Brown	Quarter 3 2025/26
Local Audits for Service Improvement	**Blueteq assurance audit** A random sample of 10 patients will be selected and their clinical notes will be checked to ensure that they meet the criteria for treatment.	Quarter 3 2025/26		Chief Pharmacist Claire Jones	Quarter 4 2025/26

Local Audits for Service Improvement	**Controlled Drugs Management in clinical areas across PTHB.**	Quarter 4 2025/26		Controlled Drugs Accountable Officer Jayne Price/Internal Audit	Quarter 4 2025/26

Corporate Functions					
Resuscitation					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Other National Audit	Completion of DNACPR	Q3 2025	Resuscitation	Resuscitation Officer	Q4 2025
Infection Prevention and Control					
Local Audits for Service Improvement	Organisational IPS Environmental Audit	Annually	IPC Staff	IPC Lead	Q4 2025
Local Audits for Service Improvement	IPS Environmental Audit (More frequent/smaller)	Quarterly	IPC Staff	IPC Lead	Quarterly
Local Audits for Service Improvement	Mental Health Ward Environmental Audit	Annually	Ward Staff	IPC Lead	Q4 2025
Local Audits for Service Improvement	Hand Hygiene	Quarterly	Ward Staff	IPC Lead	Quarterly

Mental Health and Learning Disabilities

Mental Health

Driver	Audit Title	Start Date	Service	Lead	End Date
Audits in response to Identified Risk	Audit of Environmental Ligature Risk Assessment	Quarter 1	All Mental Health Units	Senior Nurse - Inpatient Matron role	Quarter 2
Audits in response to Identified Risk	Audit of WARRN risk assessments	Quarter 4	All Mental Health Units	Consultant Nurse/Governance Lead	
Audits in response to Identified Risk	Audit of Security Risk Assessment	Quarter 2	All Mental Health and LD Units	Head of MH Operations	
Local Audits for Service Improvement	Audit of Care and Treatment plans	Quarter 2	All Mental Health Units	CTP Lead/Governance Lead	
National Programme Audit	NCISH Suicide audit	Quarter 2	All Mental Health Units	Suicide and SH Prevention Lead	
National Programme Audit	National review of schizophrenia audit	Quarter 4	All Mental Health Units	Clinical Director MH&LD	
Local Audits for Service Improvement	Inpatient Physical health monitoring audits	Quarter 1	Ward units	Clinical Director MH&LD	Quarter 2
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 1	Ward units	Senior Nurse - Inpatient Matron role	Quarter 2
Local Audits for Service Improvement	Medicine management audit	Quarter 1	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 2

Local Audits for Service Improvement	Hand hygiene/Matress audits	Quarter 1	Ward units	Ward Managers	Quarter 2
Local Audits for Service Improvement	Record Keeping	Quarter 1	All Mental Health Units	Team Leads/Ward Managers/IG	Quarter 2
Local Audits for Service Improvement	DNAs	Quarter 1	All Mental Health Units	Business and Performance Manager	Quarter 2
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 1	Ward units	Service Managers and Ward Managers	Quarter 2
Local Audits for Service Improvement	Welsh Language Active Offer Audits	Quarter 3	All Mental Health & LD Units	TBC	
Local Audits for Service Improvement	WNB	TBC	CAMHS	CAMHS Operational Lead	
Local Audits for Service Improvement	Early Intervention in Psychosis	Quarter 2	CAMHS	CAMHS Operational Lead	Quarter 3
Local Audits for Service Improvement	Outcome Measure Audit	Quarter 2	CAMHS	CAMHS Operational Lead	Quarter 3
Local Audits for Service Improvement	LPMHSS Pathway Audit	Quarter 2	Community Based	Service Manager LPMHSS/Psychology	Quarter 3
Local Audits for Service Improvement	Policy Audit	TBC	All Mental Health & LD Units	CPAG	
Local Audits for Service Improvement	Community Medical Caseload and Admin	Quarter 1	All Mental Health Units	Clinical Director MH&LD	Quarter 2
Local Audits for Service Improvement	S117 Audit	Quarter 1	All Mental Health Units	Head of MH Operations	Quarter 2
Local Audits for Service Improvement	MH Act Compliance	Quarter 2	All Mental Health Units	HoMH Nursing	Quarter 3
Local Audits for Service Improvement	Adult & Older Adult CMHT MDT Audit	Quarter 2	Community Based	Head of MH Operations	Quarter 3

Local Audits for Service Improvement	Epilepsy audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Liaison data audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Champion training audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Anti-psychotic and physical health audit	Quarter 2	All Mental Health & LD Units	Consultant Psychiatrist/Head of SOAD	Quarter 3
Local Audits for Service Improvement	H&S audit doors/alarms/ radio functions	Quarter 1	Ward Based	Service Managers and Ward Managers	Quarter 2
Local Audits for Service Improvement	Medical Devices audit	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Local Audits for Service Improvement	Environmental audit/ cleanliness/risks	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Local Audits for Service Improvement	Fire risk audit drills/points/equipment	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Audits in response to Identified Risk	Therapeutic observations audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	WCCIS and V4 MHM forms audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	Advocacy audit	Quarter 2	All Mental Health & LD Units	Head of LD	Quarter 3
Audits in response to Identified Risk	Discharge letters audit from in-patient services.	Quarter 2	All Mental Health & LD Units	Clinical Director MH&LD	Quarter 3
Audits in response to Identified Risk	Escorting patients off hospital grounds	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	Educational audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3

Audits in response to Identified Risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3
Audits in response to Identified Risk	Older adult CMHT discharge audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3
Audits in response to Identified Risk	s136 audit	Quarter 2	All Mental Health & LD Units	Clinical Director MH&LD	Quarter 3

Women and Children's Service					
Midwifery					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audit for Service Improvement	All Wales Handheld Maternity Records	Rolling	Maternity	Clinical Supervisor for Midwives	July 2025
Service evaluation	Maternity Triage Process Review		Maternity	MatNeo Champion	October 2025

Local Audit following change to policy or procedure	VTE Guideline		Maternity	Clinical Supervisors for Midwives	November 2025
Local Audit following change to policy or procedure	Spontaneous Rupture of Membranes Guideline		Maternity	Consultant Midwife	April 2025
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning		Maternity	Perinatal Mental Health	December 2025
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH *(Business as usual)*		Maternity	Consultant Midwife	June 2025
Local Audit for Service Improvement	Clinical Information Sharing Caseload *(Business as usual)*		Maternity	Clinical Supervisors/Consultant Midwife	March 2026
Children's Nursing Leadership Team					
Local Audit for Service Improvement	Transition	Q2 &Q4	Children's Services	SD	6 monthly
Local Audit for Service Improvement	Children's Continuing Care	Q4	Children's Services	SD	Q4
Children's Public Health nursing (Health Visiting & Flying Start)					
Local Audit for Service Improvement	Routine Enquiry (Quarterly)	Q1	Generic HV& Flying Start	WD/Delegate	Q3
Local Audit for Service Improvement	Record Keeping	Annual	Generic HV& Flying Start	WD/Delegate	Record Keeping
Local Audit for Service Improvement	Was Not Brought	Monthly	Generic HV& Flying Start	WD/Delegate	Monthly
Local Audit for Service Improvement	Welsh Levels of Care	Quarterly	Generic HV& Flying Start	WD/Delegate	Quarterly

Local Audit for Service Improvement	Implementation of Guideline: Health Visiting Caseload cleanse	6monthly	Generic HV& Flying Start	WD/Delegate	6monthly
Local Audit for Service Improvement	Cypris Data Compliance	6 monthly	Generic HV& Flying Start	WD/Delegate	6 monthly
School Nursing and Immunisation Team					
Local Audit for Service Improvement	Was Not Brought	Monthly	School Nursing/Imms	WD/Delegate	Monthly
Local Audit for Service Improvement	Flu Immunisation Uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	DTP MenACWY Imms Uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	HPV Immunisation uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	E-Consent	Following each Imms programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	Level 1 Continence Delivery	Quarterly	School Nursing	WD/Delegate	Quarterly
Local Audit for Service Improvement	Record Keeping	Annual	SN/Imms	WD/Delegate	Q4
Local Audit for Service Improvement	Handwashing	Annual	SN/Imms	WD/Delegate	Q4
Local Audit for Service Improvement	ANTT (Immunisation nurses)	Annual	Immunisation team	WD/Delegate	Q4
	Safeguarding Caseloads	Quarterly	School Nursing Team	WD/Delegate	Quarterly
Community Paediatrics					

National Audit	National Audiology Audit	Q2	Comm Paeds	RL	Q3
Local Audit for Service Improvement	ADHD Medications	Q1	Comm Paeds	RL	Q2
Local Audit for Service Improvement	Downs Syndrome Audit	Q3	Comm Paeds	IP	Q4
Local Audit for Service Improvement	CPIP +Register review	Q4	Comm Paeds	LA/RL	Q4
Local Audit for Service Improvement	Record Keeping	Q2	Comm Paeds	SD/LA	Q3
Children's Community Nursing					
Local Audit for Service Improvement	Was not brought	Monthly	CCNS	CD/Delegate	Monthly
Local Audit for Service Improvement	Record keeping	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	ANTT	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	Paediatric Continence	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	Paediatric Epilepsy	Annual	CCNS	CD/Delegate	Quarter 4
Neuro Development Team					
Local Audit for Service Improvement	Introduction of caseload management	Monthly	ND	CD/Delegate	Monthly
Local Audit for Service Improvement	Average length of open assessment pathways	Monthly	ND	CD/Delegate	Monthly
Local Audit for Service Improvement	Record Keeping	Quarterly	ND	CD/Delegate	Quarterly
Local Audit for Service Improvement	Was Not Brought	Monthly	ND	CD/Delegate	Monthly

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident/Identified Risk
	Service Evaluation
	Other

Progress Key:

	Progress
	Complete
	On Track
	Indicates audit Rolled Forward from 2021/22 Programme
	Not undertaken due to lack of capacity

Archwilio Cymru
Audit Wales

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

Date issued: July 2025

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.

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 (the Health Board). We presented our most recent Audit Plan to the committee in March 2025.

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 2024-25 Accountability Report and Financial Statements	Executive Director of Finance, Capital & Support Services	Statutory audit of the financial statements to inform the audit opinion.	Final audit ongoing in respect of one area: Continuing Health Care Accruals. The Health Board is reworking calculations which will then be subject to audit.	TBC but will likely lead to delay in certification (previously set for 27th June)
Audit of the 2024-25 Charitable Funds Financial Statements	Executive Director of Finance, Capital & Support Services	Audit of the financial statements to inform the audit opinion.	Exact timing of audit to be confirmed. We will ensure deadline of 31 January 2026 is met.	January 2026

Performance audit update

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

Exhibit 2 – performance audit work

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

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of planned care	Executive Director of Primary Community Care and Mental Health	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Final Report	July 2025
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Executive Director of Finance, Capital & Support Services	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Project brief issued May 2025	October 2025
Structured Assessment 2025 - Core	Director of Corporate Governance/Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review:	Draft project brief issued June 2025	October 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Board transparency, effectiveness and cohesion • Corporate systems of assurance • Corporate approach to planning • Corporate financial planning, financial management and financial performance; and • Progress in meeting outstanding recommendations		
Follow Up - Review of Quality Governance Arrangements	Executive Director of Nursing, Quality, Women and Family Health	This work will follow up on the recommendations made in our 2021 audit. Our previous audit examined whether the health board's governance arrangements support delivery of high quality, safe and effective services.	Project brief issued June 2025	October 2025
Local work 2024 – review of arrangements for managing agency staff	Executive Director of Primary, Community Care and Mental Health	This work will review the Health Board's arrangements to manage agency staff use within mental health and learning disability settings. The exact scope of the work is still to be developed.	Planning	TBC

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates	To be confirmed	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. When undertaking this work, we will take into account the local work already underway examining the Health Board's arrangements for managing capital prioritisation.	Planning	TBC
Review of cancer services	To be confirmed	This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Planning	TBC

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
Cost Savings Arrangements | Audit Wales	June 2025
No time to lose: Lessons from our work under the Well-being of Future Generations Act	April 2025
The Biodiversity and Resilience of Ecosystems Duty	March 2025

Additional information

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

8 There are currently no relevant Audit Wales consultations underway.

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

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

Agenda item: 5.5

Audit Risk and Assurance Committee	**Date: 08 July 2025**
Subject:	Counter Fraud Update Report
Approved and presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Matthew Evans Head of Counter Fraud
Other Committees and meetings considered at:	N/A

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 2025/26.

RECOMMENDATION(S):

The Audit Risk and Assurance Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
Y		Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	The matters covered in this report are aimed at the strategic objective of transforming the Health Board into an Organisation with commitment to reducing economic crime levels to an absolute minimum and keeping them there in line with the requirements of NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Measures.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

The Counter Fraud Update Report updates the committee on key activity and developments in relation to the Counter Fraud Work Plan 2025/26.

HEADING:

See attachment

NEXT STEPS:

The Committee is asked to Note the Counter Fraud update report.

IMPACT ASSESSMENT

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

QUALITY:

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

EQUALITY:

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

RISK ASSESSMENT:

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

Powell,Bethan
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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Item 5.6

Counter Fraud Update Report

08 July 2025

Counter Fraud Update Report

1. INTRODUCTION

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

2. BACKGROUND

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

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

3. RESOURCE UTILISATION

Resource utilised in line with the four Strategic Areas aligned to NHS Counter Fraud Standards is presented below.

Strategic Area	Resource Allocated For FY 2025/26	Resource Used as of 25 June 2025
Strategic Governance	**45**	**16**
Inform and Involve	**60**	**8**
Prevent and Deter	**103**	**14**
Hold to Account	**100**	**40**
TOTAL	**308**	**77**

4. STRATEGIC GOVERNANCE

The NHS Counter Fraud Authority have now issued guidance in relation to the Economic Crime and Corporate Transparency Act 2023. The new legislation introduces a new offence of failure to prevent fraud and the Health Board will be required to comply. A review has been undertaken and findings presented in Appendix 1 to this report. The new legislation comes into effect on the 01 September 2025.

5. INFORM AND INVOLVE

The Counter Fraud Team are exploring the use of Viva Engage, an internal social media platform part of the Microsoft 365 package suite, as part of multi-modal means of raising awareness amongst a dispersed workforce. The use of Viva Engage has been trialled at Swansea Bay UHB with good early success and the use in Powys THB is envisaged to sit in amongst current awareness programme as a bite sized

less formal means of reaching staff with the counter fraud message.

6. PREVENT AND DETER

An update on National Fraud Initiative progress is presented at Appendix 2 to this report.

7. HOLD TO ACCOUNT

The status of the LCFS investigative caseload is set out below in anonymised data.

Reference	Title	Type	Subtype
INV/25/01658	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01647	Private treatment on NHS patient	NHS Staff Fraud - Dental	Charging for NHS Treatment
INV/25/01522	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01521	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01520	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick
INV/25/01519	Abuse of Position	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/25/01215	Selling prescription medication	NHS Staff Fraud - Employee fraud	Theft of Prescription Medication
INV/25/01130	False Representation - Volunteer Public Member Validation	NHS Staff Fraud - Employee fraud	Travel/subsistence fraud
INV/25/00243	Alleged Diversion of Ring Fenced Funding	NHS Systems Fraud	Financial Diversion
INV/25/00156	Prescription Fraud - Patient living in England	NHS Patient Fraud	NHS Patients - Misuse of prescriptions
INV/24/03253	Working Elsewhere - Dual Working	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/01904	Theft of NHS Assets	NHS Staff Fraud - Employee fraud	Employee Fraud - Other
INV/24/00525	Working Whilst Sick	NHS Staff Fraud - Employee fraud	Working Whilst Sick

A Report on the Offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023

Author: Michelle Newport-Edwards
Local Counter Fraud Specialist

Date: June 2025

1. SITUATION

1.1. The Economic Crime and Corporate Transparency Act 2022 (ECCTA 2023) was created to strengthen the UK's ability to tackle fraud, money laundering and other forms of economic crime. ECCTA 2023 represents a major overhaul of the UK Government's framework for tackling financial crime and has brought into force several significant changes and bolstered existing legislation by introducing stricter regulation and increased transparency around corporate activities.

1.2. One of the most significant changes introduced by ECCTA 2023 is the new corporate offence of the failure to prevent fraud which comes into force on 1st September 2025.

1.3. Under the offence *an organisation may be criminally liable where an employee, agent, subsidiary, or other 'associated person', commits a fraud intending to benefit the organisation and the organisation did not have reasonable fraud prevention procedures in place*.

1.4. The offence will also apply where *the fraud offence is committed with the intention of benefitting a client of the organisation. It also does not need to be demonstrated that directors or senior managers ordered or knew about the fraud.*

1.5. As the offence sits alongside existing legislation tackling fraud and economic crime it means that an individual can be prosecuted for fraud while the organisation may also be prosecuted for failing to prevent it.

1.6. Prior to the offence coming into force the Government has issued guidance for organisations which defines the offence, the types of fraud covered by the offence, who can commit it and importantly the procedures organisations can put in place to prevent persons associated with them from committing fraud offences. NHS Counter Fraud Authority have since issued NHS specific guidance.

1.7. This report considers all available guidance and the Health Board's current policies and procedures that are in place to counter fraud and economic crime to seek to provide assurance that we have reasonable measures in place and any recommendations for

additional controls to prevent the Health Board potentially being prosecuted for the Offence of Failure to Prevent Fraud.

2. BACKGROUND

2.1. In June 2022 the Law Commission published a paper entitled “Corporate Criminal Liability: an options paper” which examined options for improvement to the law with the aim of ensuring corporations are effectively held to account for committing serious crimes.

2.2. This led to the creation of ECCTA 2023 and the corporate offence of failure to prevent fraud. The aim of the offence is to drive a change in corporate culture by encouraging more companies to implement or improve fraud prevention procedures.

The Offence

2.3. Section 199 (1) and (2) of ECCTA 2023 defines the 2 ways in which the failure to prevent fraud offence can be committed:-

2.3.1. Section 199(1) is aimed at large organisations and states that an offence is committed where:-

2.3.1.1. the relevant body is a large organisation

2.3.1.2. an associate of that relevant body commits a fraud offence

2.3.1.3. the fraud offence takes place during a financial year of the relevant body

2.3.1.4. the fraud offence is committed with the intention to benefit, either directly or indirectly the relevant body or any person to whom, or to whose subsidiary undertaking, the associate provides services on behalf of the relevant body.

2.3.2. Section 199(2) is aimed at capturing parent companies when employees of their subsidiaries commit fraud. It provides that a relevant body will be guilty of failure to prevent fraud where:-

2.3.2.1. an employee of the relevant body commits a fraud offence intending to benefit, either directly or indirectly, the relevant body

2.3.2.2. the fraud offence takes place during a financial year of a parent undertaking of which the relevant body is a subsidiary undertaking, and

2.3.2.3. the parent undertaking is a relevant body which is a large organisation

Large Organisations

2.4. The offence is applicable to all sectors but specifically 'large organisations.' Section 201 of ECCTA 2023 defines a large organisation as an organisation that meets two or three of the following criteria

2.4.1. More than 250 employees

2.4.2. More than £36 million in turnover

2.4.3. More than £18 million in total assets

2.5. The above criteria apply to the whole organisation, including subsidiaries, regardless of where the organisation is headquartered or subsidiaries are located.

Fraud Offences

2.6. ECCTA 2023 refers to 'fraud offences' and these are defined at Section 199(6) as any of the fraud and false accounting offences outlined in Schedule 13 of ECCTA 2023 including the aiding, abetting, counselling, or procuring the commission of any of those offences. The guidance issued by the government confirms that these are known as 'base fraud' offences and include the following:-

2.6.1. Fraud by false representation – Section 2 Fraud Act 2006

2.6.2. Fraud by failure to disclose – Section 3 Fraud Act 2006

2.6.3. Fraud by abuse of position – Section 4 Fraud Act 2006

2.6.4. Participation in a fraudulent business – Section 9 Fraud Act 2006

2.6.5. Obtaining Services dishonestly – Section 11 Fraud Act 2006

2.6.6. Cheating the Public Revenue – Common Law

2.6.7. False Accounting – Section 17 Theft Act 1968

2.6.8. False Statements by Company Directors – Section 19 Theft Act 1968

2.6.9. Fraudulent Trading – Section 993 Companies Act 2006

When can corporate liability arise?

2.7. The failure to prevent fraud is a strict liability offence which can only be committed by corporations. The key factor in determining whether an organisation should be prosecuted for a failure to prevent fraud is the issue of 'who was intended to benefit from the fraud'. As a fraud offence can be considered complete before any gain is received ECCTA 2023 also applies the same rationale and does not require any evidence that the organisation benefitted from the fraud. This means that corporate liability can arise simply by demonstrating that the organisation was intended to be the beneficiary of the fraud whether directly or indirectly.

2.8. An organisation could also be prosecuted for failing to prevent fraud even in circumstances where the fraud is committed by subsidiary's employee, for the benefit of the parent organisation and the parent organisation did not take reasonable steps to prevent it.

2.9. There is no requirement for an organisation to be aware of the fraud to be held criminally responsible.

2.10. It is also important to note that an organisation will not be prosecuted for a failure to prevent fraud where the organisation is the victim or the intended victim of a fraud that was supposed to benefit the organisations clients.

Who commits the offence leading to a potential prosecution?

2.11. ECCTA 2023 confirms that a base fraud offence must be committed by an 'associate of that relevant body'. The Government guidance confirms that "an employee, an agent or a subsidiary of the relevant body is automatically considered an 'associated person' for the purposes of the offence. It should also be noted that a person who provides services for or on behalf of the relevant body is also an associated person during the period that they are providing those services.

2.12. Corporate liability will only arise if an individual commits a base fraud offence whilst providing services and acting in the capacity of a person associated with the relevant body. A base fraud offence that takes place outside this capacity, such as in the person's private life will not give rise to corporate liability.

2.13. It should also be noted that in establishing if a particular individual is an associated person there is a requirement to consider all relevant circumstances and not simply just the nature of the relationship between that individual and the organisation. This means that an individual can be considered an associated person under ECCTA 2023 even in circumstances where there is no contractual relationship.

Defence

2.14. To avoid prosecution for a failure to prevent fraud ECCTA 2023 at Sections 199 (4) and 199 (5) stipulates that an organisation will have a defence if they are able to demonstrate:

That they have reasonable procedures in place to prevent fraud, or

That it was not reasonable in all the circumstances to expect the organisation to have any fraud prevention procedures in place.

2.15. The question of whether an organisation has reasonable procedures in place to prevent fraud in the context of a prosecution is something that can only be resolved by a court. If an organisation is prosecuted for a failure to prevent fraud, then the onus will be on the organisation to prove 'on a balance of probabilities' that it had reasonable procedures in place to prevent fraud.

What are reasonable fraud prevention procedures?

2.16. The Government guidance suggests that for an organisation to demonstrate that they have reasonable procedures in place they need to implement a fraud prevention framework which should be informed by six principles:-

Top Level Commitment

Risk Assessment

Proportionate risk-based prevention procedures

Due Diligence

Communication (Including Training)

Monitoring and Review

2.17. The guidance is clear that the principles outlined above are intended to be flexible, outcome focussed and proportionate to the risk of fraud faced by the organisation.

2.18. It is important to note that if an organisation chooses to depart from some of the suggested procedures outlined within the government guidance does not automatically mean that, that organisation did not have reasonable fraud prevention procedures in place. Equally even strict compliance with the guidance will not necessarily amount to having reasonable procedures where the relevant body faces particular risks arising from the unique facts of its own business that have not been addressed

3. ANALYSIS

3.1. The LCFS has considered the guidance issued by the UK Government and that of NHS Counter Fraud Authority and we are of the view that the Health Board would meet the definition of a large organisation for the purposes of ECCTA 2023, therefore we need to consider the question of whether we have reasonable procedures in place to prevent fraud.

3.2. Powys Teaching Health Board is required to comply with the Counter Fraud Government Functional Standards - NHS Requirements. The guidance issued by the

UK Government acknowledges that public sector organisations are likely to have many of the elements of the fraud prevention framework already in place but there may be a need to adapt these procedures to ensure they consider the failure to prevent fraud offence.

3.3. The Health Board currently has measures in place via compliance with the Counter Fraud Standards which map directly to the six principles set out for defence against the new corporate offence:-

Top Level Commitment

Links with Standard component 1; to have an accountable individual at board level who is responsible for fraud, bribery and corruption. The Health Board is currently Green rated for this standard with Director of Finance holding responsibility for counter fraud matters and a nominated Fraud Champion.

Risk Assessment

Links with Counter Fraud Standard component 3; to have a fraud, bribery and corruption risk assessment that feeds into the organisational workplan and is managed in line with the organisation's local risk management policies. The Health Board is currently Green rated for this standard with a maturing integration with established risk management processes.

Proportionate Risk-Based Prevention Procedures

Links with Counter Fraud Standard component 5; to have an annual action plan that is informed by fraud risk, identifying activities to improve capability and resilience. The Health Board is currently Green rated for this standard with an annual Counter Fraud Work Plan agreed with the Director of Finance and approved by the Audit Committee.

Due Diligence

Links to a number of components including Counter Fraud Standard component 2; the organisation should align their counter fraud, bribery and corruption work to the NHSCFA's central strategy. The Health Board is currently Green rated for this standard with strategy set out in the Counter Fraud Work Plan and within Health Board policies such as the Counter Fraud Policy and Response Plan.

Communication (Including Training)

Links with Counter Fraud Standard component 7; to have well established and documented reporting routes for staff, contractors and members of the public where necessary to report fraud suspicions. The Health Board is currently rated Green for this standard with availability of multi-modal reporting routes for staff which are well established and documented.

This also links with Counter Fraud Standard component 11; ensuring that all staff have access to and undertake fraud awareness, bribery and corruption training as appropriate to their role. The Health Board is currently Green rated for this standard but continued compliance is always looking to improve this area.

Monitoring and Review

Links with Counter Fraud Standard component 6; to identify and report upon annual outcome-based metrics to support improvement in performance. The Health Board is currently rated Green in this area with KPIs set and measured on a quarterly

basis which are submitted to Welsh Government and presented to the Health Board's Audit Committee for review.

4. RECOMMENDATIONS

4.1. ECCTA 2023 can only strengthen our collective fraud prevention efforts by enabling us to create an environment with an increased anti-fraud culture. This will continue to evolve once the offence comes into force and organisations are prosecuted for a failure to prevent fraud.

4.2. Currently the LCFS would make the following suggestions to help strengthen our position in demonstrating that we have reasonable procedures in place

4.2.1. Conduct a formal Risk Assessment, to incorporate the NHS Counter Fraud Authority Advisory Checklist, on the potential risk to the Health Board of them being prosecuted for a failure to prevent fraud. This will enable us to formalise where we currently are, identify any weaknesses and log the risk for future review.

4.2.2. Engage with Procurement and Finance to ensure that all policies, procedures and contracts are in compliance with ECCTA 2023 and that documentation is updated to include reference to the new offence.

4.2.3. Counter Fraud should be included as a Risk Domain and as a Specialist Advisor in the Health Boards overarching Risk Management Policy.

4.2.4. Consider making Counter Fraud Awareness training a mandatory requirement for all staff. This will be a key element to any defence the Health Board is required to raise should an employee go rogue which results in the Health Board benefitting.

Appendix 1 – Useful Links for Further Reading

[Failure to prevent fraud offence | NHS Counter Fraud Authority]

[Offence of 'failure to prevent fraud' introduced by ECCTA - GOV.UK]

Appendix 2 – NHS Counter Fraud Authority Advisory Checklist

Principle	Compliance
Top Level Commitment	
Having an accountable individual at board level who is responsible for fraud, bribery and corruption.	
The board of directors, partners and or relevant senior management of a relevant organisation committing to preventing fraud and fostering a culture in which fraud is never acceptable.	
The chief executive officer (or equivalent) making a statement about the organisation's fraud prevention approach and measures.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct, and ensuring that there is board-level oversight of whistleblowing.	
Discussion of key issues amongst senior management, thinking about key milestones between now and implementation date and if appropriate and necessary, taking professional legal advice on how the offence applies to the organisation.	
Senior management should be aware of and accept the initiatives and ensure that they are embedded in corporate culture.	
Monitoring the progress of measures to mitigate identified risks at a senior level.	
Fraud Risk Assessment	
Having a fraud, bribery and corruption risk assessment that feeds into the organisational work plan and is managed in line with the organisations local risk management policies (GovS 013 Component 3: Fraud, bribery and corruption risk assessment).	
Undertaking risk analysis in line with Government Counter Fraud Profession fraud risk assessment methodology and recording this on the appropriate risk registers.	
Consideration of fraud risks within any associated subsidiary of the NHS organisation.	
Taking legal advice where appropriate and necessary on the identification of associated persons (employees, agents, subsidiaries or other person who provides services for or on behalf behalf of the organisation). For example, contractors may be associated persons when they are providing services for or on behalf of the organisation.	
Undertaking effective fraud risk assessments which will inform proportionate fraud prevention controls	
Consideration of whether current risk assessments cover the risk of fraud that is in scope of this offence (fraud that is intended to benefit the organisation, or in some circumstances, it's clients and fraud committed by 'associated' persons).	
Adaptation of current risk assessments to include fraud risks in scope of this offence.	

Principle	Compliance
If appropriate, responsibility for conducting a documented risk assessment which is kept under regular review, assessing the nature and extent of the organisations exposure to the risks of associated persons committing fraud in scope of this offence.	
Consideration of the changes made to the 'identification doctrine' under ECCTA and whether current risk assessments cover 'senior manager' risk (see section on The ECCTA for guidance on the identification doctrine and the definition of 'senior manager').	
Proportionate Risk Based Prevention Procedures	
Having an annual action plan that is informed by fraud risk, identifying activities to improve capability and resilience (GovS 013 Component 5: Annual action plan).	
Using the fraud prevention information, guidance and resources provided by NHSCFA, ensuring that clear, practical and enforced procedures are in place to prevent fraud by associated persons.	
Ensuring that these procedures are proportionate to the fraud risks it faces and to the nature, scale and complexity of the organisation's advice.	
Thinking about what a fraud prevention plan/framework will look like (i.e. what the proportionate, risk-based, fraud prevention procedures will be).	
Checking what anti-fraud procedures are currently in place and assessing whether they are sufficient to counter the risks identified in the risk assessment.	
Using NHSCFA's fraud prevention guidance documents to develop or adapt local fraud prevention policies, procedures and systems (see guidance on procurement fraud, payroll fraud, invoice and mandate fraud, pre-contract procurement fraud, management and control of prescription forms, employment agency fraud).	
Having a proportionate fraud prevention policy which may form part of a general code of conduct or which may be a stand-alone policy.	
Deciding what resources and governance structures are needed to adapt to this change in the law.	
Being able to demonstrate a strong anti-fraud culture within the organisation.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct and ensuring that there is board-level oversight of whistleblowing.	
Having disciplinary procedures in place, which enable the organisation to take appropriate disciplinary action against an employee who commits a fraudulent act.	
Establishing clear reporting pathways in place for reporting suspected fraud.	
Adaptation of existing policies to include the failure to prevent offence (for example, whistleblowing, HR, fraud, external communications, media etc).	

Principle	Compliance
Ensuring that sub-contractors are within the scope of fraud prevention procedures.	
Ensuring that fraud prevention procedures address how the relevant measures will prevent fraud by service provision.	
For contracting relationships, updating standard wording to require compliance with fraud prevention policies.	
Due Diligence	
Ensuring alignment of the organisation's counter fraud, bribery and corruption work to the NHSCFA's central strategy (GovS 013 Component 2: Counter fraud, bribery and corruption strategy).	
Application of proportionate and risk based due diligence procedures in respect of persons who perform or will perform services for or on its behalf to mitigate identified fraud risks.	
Ensuring due diligence procedures are in place and considering the organisation's existing due diligence checks in relation to such parties and whether they are sufficiently robust to identify previous allegations or suspicions of fraud against a third party.	
Reviewing agreements with any agents, distributors, representatives, and other third-party intermediaries to ensure they contain appropriate contract terms in relation to fraud.	
Ensuring pre-employment checks and procedures are in place.	
Implementing the actions within the Due Diligence Quick Guide to assist NHS procurement teams in making informed risk management decisions on whether to engage with suppliers.	
Communication (including training)	
Having well established and documented reporting routes for staff, contractors and members of the public where necessary to report fraud suspicions (GovS 013 Component 7: Reporting routes for staff, contractors and members of the public).	
Ensuring all staff have access to and undertake fraud awareness, bribery and corruption training as appropriate to their role (GovS 013 Component 11: Access to and completion of training).	
Regular measurement of staff awareness levels.	
Reviewing and delivering appropriate training to ensure awareness of coming changes.	
Ensuring that the fraud prevention policy or code of conduct is proactively communicated to all staff, fully implemented, and demonstrably effective.	
Measuring levels of awareness of the code of conduct among staff.	
Being able to demonstrate a strong anti-fraud culture within the organisation.	
Ensuring that an effective whistleblowing facility is in place to facilitate the reporting of allegations or suspicions of fraud and other criminal conduct.	
Ensuring that the NHS Fraud and Corruption Reporting Line (telephone hotline and online reporting tool) is publicised.	

Principle	Compliance
Having a mechanism for recording referrals and allegations of suspected fraud, bribery and corruption.	
Using NHSCFA's fraud awareness toolkit to raise awareness of NHS fraud.	
Using communication as a fraud fighting tool.	
Using the NHS Fraud Reference Guide to raise awareness of types of NHS fraud.	
Seeking to ensure that it's prevention policies and procedures are communicated, embedded and understood throughout the organisation, through internal and external communication.	
Monitoring and Review	
Identifying and reporting upon annual outcome-based metrics to support improvement in performance (GovS 013: Component 6: Outcome based metrics).	
Monitoring and reviewing its fraud prevention procedures and making improvements where necessary.	
Learning from investigations and whistleblowing incidents and reviewing information from its own sector.	
Reviewing and updating policies and procedures.	
Ascertaining what anti-fraud procedures are currently in place.	
'Testing' procedures.	
Reviewing internal systems and controls.	
Thinking about whether internal investigation mechanisms need to be updated.	

National Fraud Initiative
Progress and Outcomes

Matched Datasets Background

Payroll to Payroll

To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time.

The criteria for a match are a person having one full-time post plus at least one other post elsewhere.

Payroll to Creditors

The match identifies instances where an employee and creditor are linked by the same bank account (report 80) or the same address (report 81) to identify employees with interests in companies with which your organisation is trading.

This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.

Duplicate Creditors by Credit Reference

Duplicates identified in this match suggest poor creditor management as the system has permitted a creditor reference to be used more than once.

Duplicate Creditors by Creditor Name

To identify instances where the same supplier has been set up with more than one reference number on the system thus increasing the potential for creditors to obscure fraudulent activity.

Duplicate Creditors by Address Detail

To identify multiple creditors operating at the same address. These may represent simple errors, where the same creditor may have been set up twice using a slightly different spelling, for example LIMITED and LTD, or an attempt to obscure fraudulent activity.

Duplicate Creditors by Bank Account Number

This output shows where the same bank account details appear on more than one record. Of particular interest is where the same bank details are shown against suppliers with different names. These may indicate where a supplier has changed trading name but the standing data has not been updated to reflect this or there are links between companies with different trading names.

Duplicate Records by Reference, Amount and Creditor Reference

This match highlights possible duplicate payments in excess of £500 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Duplicate Records by Invoice Amount and Creditor Reference

This match highlights possible duplicate payments in excess of £1,000 that may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff. There are likely to be more matches than in report 707 as this report does not require the invoice reference field to match.

VAT Overpaid

This report identifies instances where VAT may have been overpaid. This is based on the information provided within the NFI invoice history data submission and the output includes the level and scale of overpaid VAT. The VAT amount is compared to a calculated maximum VAT of 20%, the maximum VAT rate in the payment period covered by the NFI exercise.

Duplicate Records by Supplier Invoice Number and Invoice Amount but Different Creditor Reference and Name

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Duplicate Records by Postcode, Invoice Date and Invoice Amount but Different Creditor Reference and Supplier Invoice Number

This match highlights possible duplicate payments for the same goods/services but to creditors with different reference numbers, which may have arisen as a result of poor controls or fraudulent activity by suppliers and/or staff.

Procurement - Payroll to Companies House (Director)

To identify potential undeclared interests that have given a pecuniary advantage. To do this we have matched your payroll data to companies house information and then to your creditors data.

The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with (Report 750) and those where the employees address appears to have links to the company directors or the company (Report 752).

Report ID	Report Title	Responsible Lead	Total Matches	Status	Closed Matches	Further Enquiries	Matches Outstanding
66	Payroll to Payroll	Counter Fraud	35	Opened	30	5	0
68.1	Payroll to Payroll - Phone Number		2	Opened	1	0	1
78	Payroll to Pensions	Pensions/Counter Fraud	31	Not Opened	0	0	31
81	Payroll to Creditors	Counter Fraud	22	Not Opened	0	0	22
700	Duplicate creditors by creditor reference	NWSSP -Accounts Payable/Finance	782	Not Opened	0	0	782
701	Duplicate creditors by creditor name		9	Not Opened	0	0	9
702	Duplicate creditors by address detail		44	Not Opened	0	0	44
703	Duplicate creditors by bank account number		56	Not Opened	0	0	56
708	Duplicate records by amount and creditor reference		1279	Not Opened	0	0	1279
709	VAT overpaid		67	Not Opened	0	0	67
711	Duplicate records by invoice number and amount but different creditor reference and name		2	Not Opened	0	0	2
712	Duplicate records by postcode, invoice date and amount but different creditor reference and invoice number		12	Not Opened	0	0	12
713	Duplicate records by postcode, invoice amount but different creditor reference and invoice number and date		2	Not Opened	0	0	2

Report ID	Report Title	Responsible Lead	Total Matches	Status	Closed Matches	Further Enquiries	Matches Outstanding
750	Procurement - Payroll to Companies House (Director)	Counter Fraud	8	Not Opened	0	0	8
752	Procurement - Payroll to Companies House (Director)		6	Not Opened	0	0	6
9999	Multiple occurrence report		1	Not Opened	0	0	1

Agenda item: 5.6

Audit Risk and Assurance Committee	**Date: 08 July 2025**
Subject:	SINGLE TENDER WAIVERS
Approved and presented by:	Director of Finance, Capital Estates and Support Services
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To inform the Audit Risk and Assurance Committee that there has been no Single Tender Waiver requests made between 1 May 2025 and 30 June 2025

RECOMMENDATION(S):

The Committee is asked to:

• **NOTE** there has been No Single Tender Waiver requests made between 1 May 2025 and 30 June 2025.

Approve/Take Assurance	Discuss	Note
N	N	Y

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

EXECUTIVE SUMMARY:
In-line with the organisation's Standing Orders, there is a requirement for all single tender waiver and extension of contracts to be reported to the Audit Risk and Assurance Committee. Single tender waiver shall only be permitted when a single firm or contractor or a proprietary item or service of a special character is required and as set out in law. Single tender waiver shall only be employed following a formal submission and with the express written authority of the Chief Executive, or designated deputy having taken into consideration due regard of procurement requirements
HEADING:
The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its May 2025 meeting which covered the period from 1 March 2025 to 30 April 2025. It is confirmed there has been no Single Tender Waiver requests made between 1 May 2025 and 30 June 2025.

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.

IMPACT ASSESSMENT NOT REQUIRED FOR THIS REPORT

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

QUALITY:

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

EQUALITY:

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

RISK ASSESSMENT:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.7

Audit, Risk & Assurance Committee	**Date: 08 of July 2025**
Subject:	**Digital First Assurance Report**
Approved and presented by:	Claire Madsen, Executive Director of Allied Health Professions, Health Science and Digital
Prepared by:	Assistant Director of Technology & Data Operations
Other Committees and meetings considered at:	N/A

PURPOSE:

To provide a Digital First update and assurance relating to the delivery of the Digital, Data and Technology Services within Powys Teaching Health Board (PTHB).

RECOMMENDATION(S):

The Executive Committee are asked to:

- **Take ASSURANCE** that work is progressing and delivering against the 2nd year of the Digital Strategic Framework, to embed a clinically led digitally enabled service in support of Digital First as a Strategic enabler for transformation, improvement, quality, safety, and efficiency.
- **NOTE** the Digital Programme Updates.

Approve/Take Assurance	Discuss	Note
✓	x	x

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

EXECUTIVE SUMMARY:

This report will provide an overview of progress, challenges and areas needed for improvement in the following key areas:

- Technology
  - Client Services
  - Infrastructure
  - Cyber Security
  - Assets & Procurement
- Systems & Data
  - Application Support
  - Data & Business Intelligence
  - Architecture & Integration
  - Data Quality & Coding
- Digital Programmes
  - National Projects
  - Local Projects

PROGRESS UPDATE

Introduction

The Digital Services Directorate has made steady progress in the last quarter. Structural changes implemented in January are now leading to closer collaboration across, Technology, Data & Project Teams within the directorate. Incremental changes to align working practices, structured engagement and monitoring of performance is allowing identification of opportunities to work more efficiently.

In May 2024, the repatriation of IT services from Powys County Council has allowed digital services to re-focus the delivery of our services around the specific needs of a health care environment.

One year on, and the benefits described in the case for change have all been realised.

Staff transferred to PTHB within TUPE regulations currently remain on their original terms and conditions from Powys County council. Almost all staff have expressed a will to transfer to Agenda for Change terms and conditions. A transfer to NHS terms and conditions will have financial implications for the health board that will be explored in the coming year.

- **Service Continuity:** Seamless transition with no major service disruptions. IT support was maintained throughout, and staff transfer was completed smoothly.
- **Governance Integration:** IT governance structures have been integrated into PTHB's corporate and digital governance arrangements.

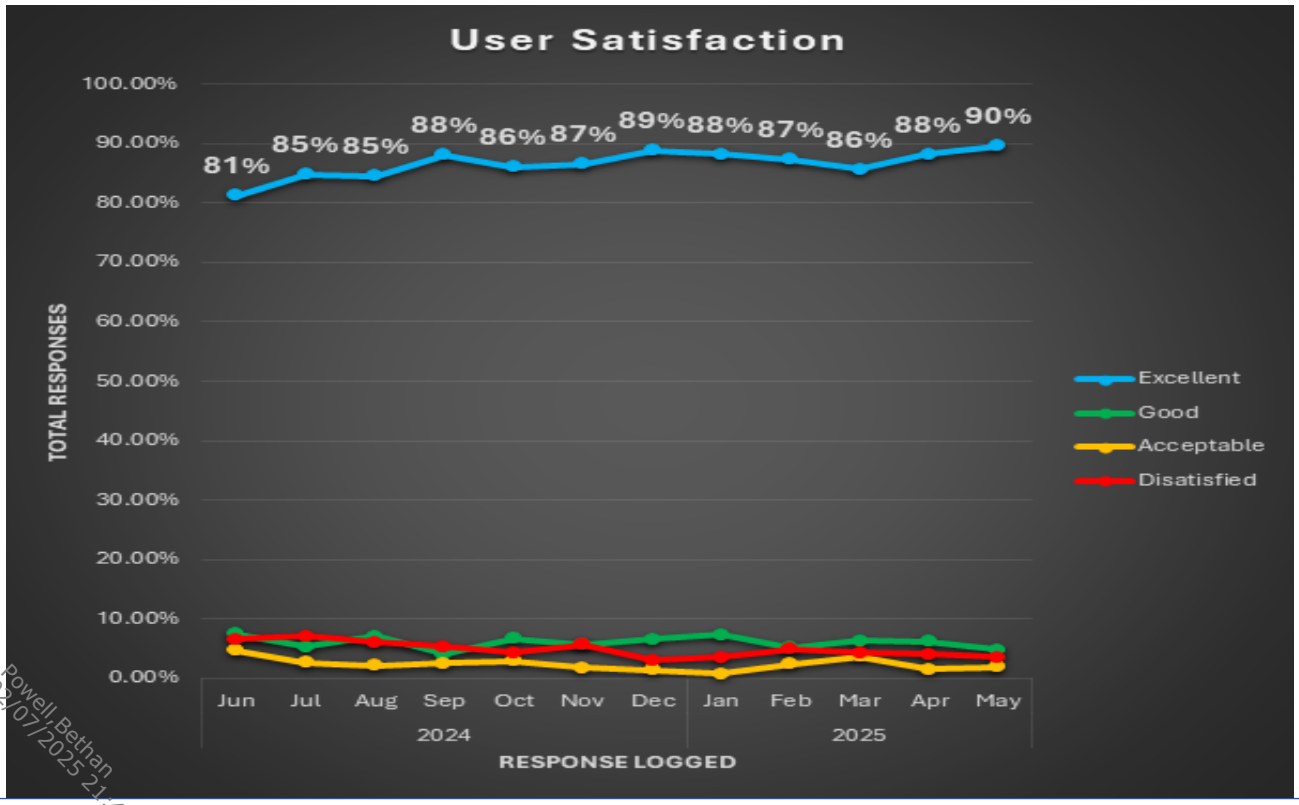
- **Improved Responsiveness:** Incident resolution times have improved by 15%, and user satisfaction with IT support rated as excellent has increased from 81% to 90% based on ongoing surveys. surveys.
- **Alignment with Digital Strategy:** IT service is now fully aligned with the Health Board's Digital Strategic Framework, enabling better support for frontline clinical systems and digital transformation programmes.
- **Local Accountability:** Enhanced ownership and accountability of IT delivery within the Health Board.
- **Workforce Stability:** All transferred staff were retained, and a skills development programme is underway.

Feedback from services has been largely positive.

"*The IT support to Planned Care has noticeably improved in the last 12 months particularly in terms of switchboard/telephony infrastructure upgrades and the general increase in response time/positive outcomes for the operational service delivery*" - **Nicola Kelly**, Senior Manager Planned Care

"I think it's been quicker and easier, and we get calls answered mostly. Resolution actually seems to happen" – **Lead Nurse**

The new target operating model implemented as part of the transition includes several KPI's focused on user experience. A target of 90% or higher set a year ago has been realised in May 2024, our ambition is to sustain or grow that level of satisfaction from our users.



The TUPE transfer of IT services from PCC to PTHB has been successfully implemented and has created a strong foundation for the Health Board's digital future.

One year on, the target operating model is evolving to include Data departments. Providing a single point of contact for support and information across all digital teams will be realised by the end of July 2025. One e-mail address, one phone number and one support portal with significant time investment in automation will manage all our Business-as-Usual Needs.

Digital Governance

A refresh of Governance and Assurance for digital initiatives and adoption of digital services across the health board two groups replace existing governance groups. These groups replace existing governance groups that did not demonstrate the required steps to realise initiatives in the past.

Digital Initiative Management Group

The digital initiative management group is being established to manage and support the introduction of new digital systems, solutions and datasets from inception to delivery. The group will ensure that cyber security and information governance are part of the larger end to end delivery of digital initiatives. The group aims to ensure that transformational initiatives are scheduled and managed end-to-end ensuring that documented benefits are monitored.

Clinical Digital Systems Group

The Clinical Digital Systems Group (CDSG) has been established to lead, oversee, and support the delivery of digital transformation in clinical services. The group is responsible for digital leadership in clinical areas and the optimisation and effective use of clinical digital systems across Powys Teaching Health Board. Its primary aim is to maximise the benefits of digital tools to enable safe, efficient, and standardised patient care, and to provide clinical leadership in setting the strategic priorities for digital development across the Health Board.

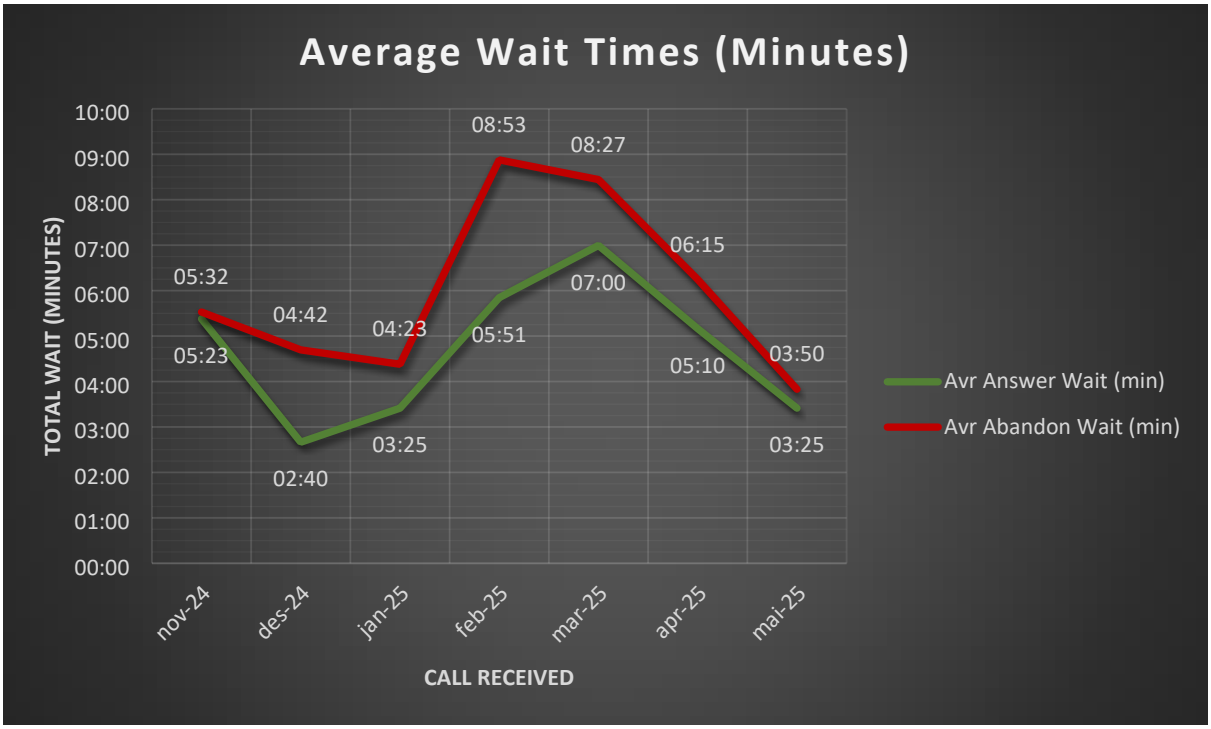
Departmental Updates

Client Services

The client services team include the service desk and the field service engineers.

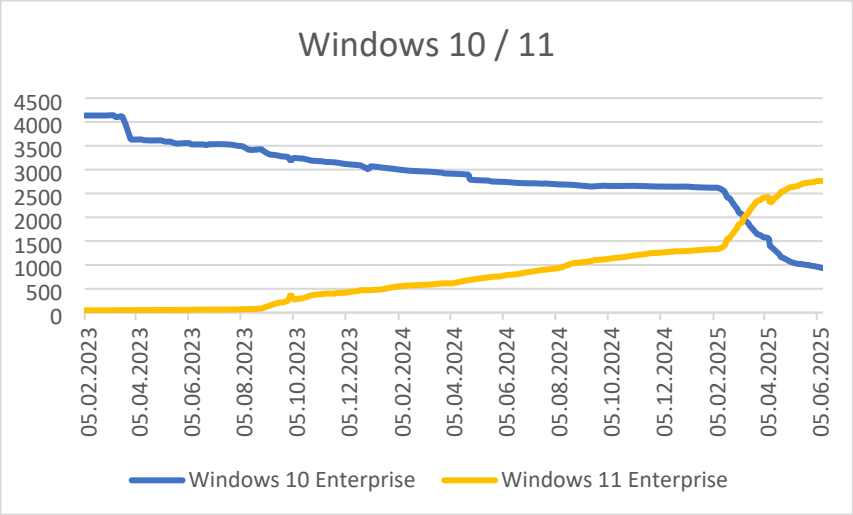
The service desk are investing significant amount of time generating standard operating procedures to support an increase in resolutions at the first point of contact for users. Alongside this the service desk are preparing to be the first point of contact for Data Teams in addition to the Technology Teams. An initiative to ensure more robust recording of resolutions and outcomes in the wider teams is allowing the service desk to not only improve service, but to improve their knowledge and skills in the process. This change will also support ongoing demand and capacity reviews and visibility across all functions within Digital Services.

The service desk are generally able to ensure phone calls are answered in under five minutes.



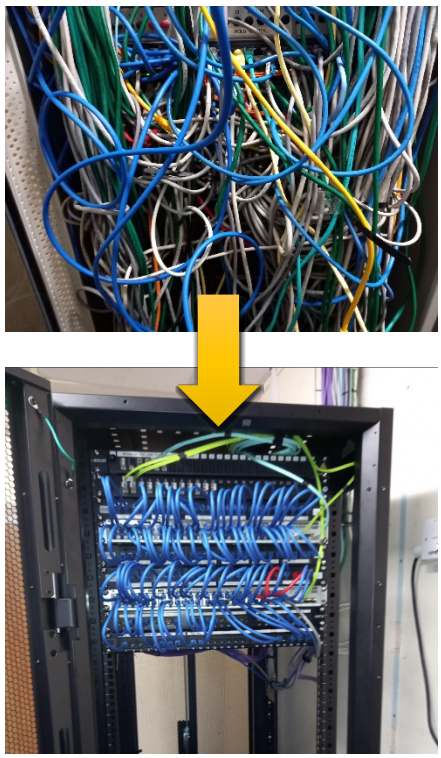
Four field service engineers are responsible for on-site support and the delivery of user equipment across the health board. Despite logistical and efficiency improvements a significant amount of time is spent travelling around the health board.

An important focus for our field services engineers is to ensure that the health board does not have any Windows 10 devices by October 2025. The large proportion of upgrades to Windows 11 have been achieved remotely, but this is not possible on all machines. This work can be time consuming for the field engineers, but achieving this objective removes financial risk of procuring extended support from Microsoft at an inflated cost and mitigates certain vulnerabilities that will arise after end of life.



We are currently anticipating being the only health board to achieve this on time by October.

Infrastructure



The infrastructure team is responsible for ensuring the health boards networking, service hosting platforms and telephony services are operational.

A programme of investment in our networking infrastructure from FY 2024/2025 is nearing completion to replace legacy and unsupported network devices and cabling across the health board.

- 60 New network switches replaced
- 9000~ network cables replaced
- 150 New Wireless access points deployed

Each of these improvements improves stability, resiliency and capacity of our network infrastructure. Wireless coverage has been increased significantly across all sites in the health board especially in wards. A new guest wi-fi service has been implemented in recent months to improve

connectivity for visitors, patients and staff when on-site. The new experience is designed to be fast and simple for everyone to use. This new service has been extremely well received in mental health wards, now allowing patients to virtually contact family and friends and access entertainment on their phones and other devices

A further piece of work is soon to start to significantly improve the availability of our datacentre networks, providing increased availability and reliability of services hosted internally. A key deliverable of this work is to remove a dependency on Brecon hospital for a disaster recovery site and replace it with entirely new infrastructure and connectivity in Spa Road. The use of Spa Road as a disaster recovery site removes a single point of failure in the BT infrastructure that both Bronllys & Brecon are dependant on.

Cyber Security

The health boards cyber security posture remains positive. Independent audits continue to show constant iterative improvement to our pro-active work to secure the health board and our lifecycle management of operating systems and software. We're able to technically demonstrate that the health board has sufficient assurances in place to resist and respond to cyber incidents.

This assurance is however limited to technical controls. The health board would benefit from several key cyber response plans and documents that would provide additional assurance. Our cyber team consists of one individual and direction has been set to ensure that new systems do not compromise our cyber posture, and that any exposure of new vulnerabilities is mitigated. This is at the expense of supporting documentation at present. A single resource for this team may pose a risk to the health boards cyber security. At present this is partly mitigated by the Assistant Director of Digital & Data Operations during absences, but this is far from ideal.

A development session for the board is being planned for November 2025 to improve cyber awareness and understand some of the risks and how they impact the health board.

Assets & Procurement

The assets and procurement team are responsible for the procurement of digital equipment and the monitoring of its lifecycle across the health board.

Procurement of equipment can be time consuming as we are unable to commit to larger investments. We have taken steps to ensure timely delivery of equipment to new starters at the expense of replacing legacy equipment currently. Several projects are allowing us to invest in replacing legacy digital equipment

Asset management of our digital estate is constantly improving, as we work with departments to release legacy and stored equipment. Several site-wide audits have been completed in the last quarter to validate our existing inventory and improve its accuracy.

We shall begin to work with service areas to validate their assets and support services areas to keep a log of their assets which will further support the asset tracking processes and accountability. There is a possibility this can be linked to service budget codes for transparency of asset numbers/cost per head count.

We are working to ensure that devices are used to their maximum value and explore all opportunities to re-use and recycle equipment rather than order new equipment for all new starters.

Responsible disposal of our digital equipment is regularly audited as part of Waste Electrical and Electronic Equipment (WEEE) regulations.

Application Support

In recent months the application support team has been merged with the WCCIS support team. This change was to support the imminent and significant changes to the health boards local and national clinical services. The new structure will remove single points of failure for our users for specific applications as the changes embed. There is a significant amount of knowledge to share carefully.

The applications support team will be a part of our KPI reporting from June 2025 allowing more detailed demand monitoring for business-as-usual activity.

The applications support team are responsible for driving adoption and improvement of our established clinical systems. In recent months the team have successfully driven adoption of WCCIS across the teams detailed below, driving significant efficiency improvements and an increase in time-to-care. We are working with the departments to measure these improvements.

- Community Cardiology
- Cardiac Nursing
- Mental Health Inpatients
- Adult Psychology

The work required to achieve efficient adoption of clinical services cannot be underestimated and has required significant investment in time to understand current processes, improve and replicate in a digital service from paper to electronic.

Data & Business Intelligence

Our reporting and dashboard work this year has focused on bringing together data from different systems to provide better insights for clinical and operational teams.

The Health Roster dashboard integrates Finance, Workforce, and WPAS data to give an interactive view of staffing costs and deployment across hospital wards. This is helping management work with ward staff to ensure staffing levels meet safety guidelines and reduce reliance on more expensive bank and agency staff.

The Maternity Dashboard has been particularly impactful, providing statistical analysis across multiple elements of the maternity service. The insights have supported the maternity team in improving how they support women through their pregnancies and identifying previously unrecognised issues across the service. Using Statistical Process Control charts and G-Charts for monitoring rare events, we've been able to give clinical staff confidence in evidencing patterns they knew existed but couldn't previously prove. This includes identifying the relationship between the decrease in smoking and the concomitant increase in vaping and providing early warning of clinical issues like changes in frequency of Post Partum Haemorrhages while confirming that other metrics remain within expected variation.

Our Cancer report provides details of treatment pathways and waiting times across all providers. This has enabled better monitoring of externally provided services by the Performance and Commissioning teams and improved the efficiency of the auditing process undertaken by Audit Wales.

The GP variation dashboards, created in collaboration with the Finance team, enable conversations with GP practices about secondary care service provision for their patients and the costs associated with that care. It is expected that the information from the dashboards will support improved decision making.

The EQ5D-L PROMS report for Powys Living Well Service allows the team to track individual service user progress over time. By linking this to pathway information in WPAS, the report provides evidence of the impact of individual clinical interventions, so interventions can be improved in response. This report has contributed to PLWS being recognised nationally for their data collection approach.

Our Safeguarding Commissioning report brings together data from multiple sources to support invoicing health boards for children placed in Powys from outside the area. This has reduced what was previously a week-long task to about two hours of work. It has also significantly increased the total invoiced as the previous methodology failed to capture all the activities.

The costed RTT report for commissioned services has provided valuable insights to both Finance and Commissioning teams for forecasting spend and supporting strategic decision-making. The data from this report was used in a business case put forward by Finance and played an instrumental role in the success of that business case.

Our work promoting Statistical Process Control charts and best practice is starting to change how teams interpret their data. Rather than subjective assessments about whether things are "going up" or "improving," teams are beginning to have more evidence-based conversations. We're still building this capability across the organisation, but early adoption within Maternity is encouraging.

Our statistical analysis proved valuable when responding to an NHS Executive query about apparent increases in stillbirths, where our analysis showed the variation was within expected limits rather than representing a genuine trend. We've also provided statistical support for service change evaluations which has helped teams understand when changes represent genuine signals versus normal variation.

We have developed a section of our warehouse with aggregated and pseudo anonymised data, making reports accessible to all health board staff.

Additionally, we created a searchable report published on SharePoint listing all our reports and their contents, significantly enhancing information access across the health board.

The Data & Business Intelligence team will be a part of our KPI reporting from July 2025 allowing more detailed demand monitoring for business-as-usual activity.

A joint agreement between Digital & Performance teams to end the procurement of CHKS dataset on the basis that DHCW were planning on developing their own dataset based on data from English health boards has not been realised. The absence of this dataset has been highlighted as an issue in recent weeks. A business case demonstrating the benefits and financial implications of re-procurement will be developed to present to IBG & Board.

Architecture & Integration

Data Quality & Coding

The data quality & coding team are responsible for ensuring data quality issues are identified and removed from our clinical systems. An initiative to move to a more pro-active approach to data quality is being considered. Preventing the input of poor-quality data in our clinical systems requires careful engagement with Service Management Boards and DHCW to improve input validation at the point of entry.

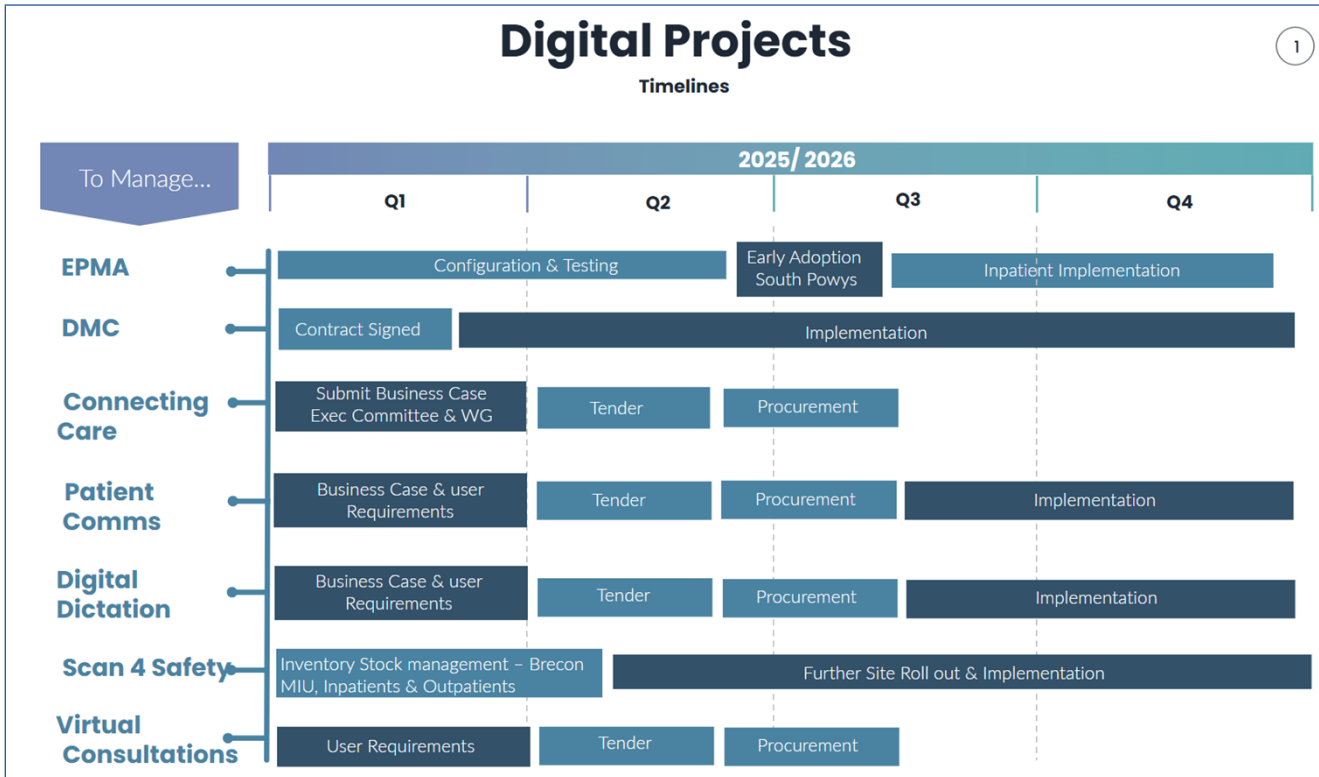
Data quality improvements completed in April are highlighted below.

- Identified 73 GPs in WPAS who have moved practices or retired and need to be closed. Existing patients need to be transferred to a new GP at the practice. This affects over 270,00 Referral and Treatment records that will need to be updated to a new GP who is currently registered.
- Reviewed the UAT instance or WPAS to ensure new Source of Referral values required to support the
- Began work to improve data quality in the consultant look up table in WPAS.
- Reviewed the Treatment Function Code list. A prioritised list has been shared with Welsh Government. Welsh Government will discuss with DHCW and to schedule time to look at this important work.
- Created a new data quality check to identify cancelled outpatient appointments where no reason for cancellation has been recorded.
- Created a new data quality check to identify appointments that do not have an outcome recorded against them after the appointment date has passed.
- Reviewed the list of Hospital Cancellation Reasons and removed any duplicate or invalid codes from the lookup.
- Resolved 32 duplicate Respiratory Syncytial Virus (RSV) vaccinations recorded in WIS.
- New Data Quality check created to identify WCCIS patient records with a referral, and no GP Practice recorded. 1774 records identified which need to be updated.
- Created a new dashboard to manage the closure of deceased patient referrals.
- Closed 1831 referrals that were open on deceased patients.
- Closed 538 forms that were linked to open referrals on deceased patients.
- Closed 427 activities that were linked to open referral on deceased patients.
- Updated 187 user accounts that were missing the individual's professional registration code.
- Started the work to align the GP lookup with the national GP data held by NHS England (for Powys GPs). So far 112 Powys GPs have been closed, and 48780 patients have had their Registered GP updated to a valid and active GP.

Despite high absence rate in the coding team, the team have maintained 100% coding compliance with defined standards.

Digital Programmes

The Digital Programme Team support several large local and national digital transformation projects. A particularly ambitions programme plan is underway with several targets that are dependant on completion before the end of this financial year.



Attend Anywhere Project Update

The attend anywhere project is established across many services within the health board. The project continues to ensure adoption and benefits realisation. A workshop to demonstrate the benefits of Attend anywhere

- On Boarding Community Cardiology 1-2-1
- On Boarding Childrens Community Nursing
- On Boarding Occupational Health Team 1-2-1
- On Boarding Well Being Service. Pilot with 1 practitioner to begin Sept.
- Initial Engagement Womens Health
- Initial Engagement WOD

Clinisys Refresh / Replacement Project

A business case is being developed to finance the refresh or replacement of this service. This service supports a feed of pathology results from Shrewsbury & Telford NHS Trust. This service has been unsupported since 2020 and will soon become end of life. There has been no cost associated with this service for several years.

Cross Border Project

The cross-border project continues to face implementation delays. Continuous pressure is being applied to DHCW from several avenues to deliver the remaining activity.

Progress: -

- Clinic / Discharge letters from WVT has gone live early in June.
- Pathology Results from WVT are scheduled to be tested in June with an anticipated go Live on w/c 7th of July.

Digital Dictation
Multiple dictation services are currently in use across the health board. This project is to procure one system that satisfies the needs of all staff requiring digital dictation.

Progress: -

- Business Case in draft
- Demo's arranged with suppliers and stakeholders to build requirements.

Digital Maternity Cymru

Digital Maternity Cymru (DMC), is a strategic initiative aimed at transforming maternity services through the implementation of a national digital maternity system.

Progress: -

- Draft DPIA reviewed by service - currently under review by IG & Digital Services
- Cyber Security documents completed and under review by Digital Services
- Initial Planning Call for HB BadgerNet Governance session held 30th June
- Regional Governance via an All-Wales Clinical Group and Digital Group

EPMA
The primary aim of the EPMA system is to eliminate paper-based prescribing and administration processes, replacing them with a fully digital solution across inpatient wards and outpatient clinics.

Progress: -

- Subgroups – Risk group has been set up and meeting monthly.
- Recruitment – Programme Manager; Ant. Digital Trainers x 2 starts (July)
- API Documentation – Completed, awaiting to be submitted with DPIA
- DPIA – in draft.
- VPN – Completed.
- Rollout Plan – Agreed for early adopter in September with remaining through to Mar 26.
- Training Platform – approved by Project Board currently with Procurement.
- Configuration spreadsheets – well underway with completion 13/6.

In an effort to ensure that the digital capabilities and skills aren't a limiting factor in the adoption for EPMA, resources have been included in the business case to recruit digital trainers to support adoption. We are hoping to demonstrate a significant business benefit of a dedicated digital training team to maintain this capability longer term to sustain the digital development of our collegues.

Digital Correspondence

The aim of this work is to gather requirements for a suitable solution to deliver digital correspondence to patients in the form of digital letter delivery, SMS Appointment Reminders and Direct to Mail printed letters where necessary. This project is to identify an alternative to the Healthcare Comms Product that was discontinued by the health board earlier this year.

Progress: -

- End users contacted for user stories feeding into user requirements.
- 12 out of 29 users have responded.
- Prioritised requirements list is currently being finalised.
- HCC project plan drafted and in development.

Powys Integrated Connecting Care Project

The need to replace the Welsh Community Care Information System (WCCIS) at PTHB has become increasingly urgent due to a combination of operational, strategic, and risk-related factors.

Progress: -

- System specification agreed with supplier
- (Internal) Investment Benefits Group (IBG) review and scrutiny
- Executive Approval (with caveats) for Single Solution across Mental Health and Community subject to funding
- Welsh Government response to Business Case – submit BC to DHCW
- Business Case submitted to DHCW.
- On-going conversations to identify funding source.

NEXT STEPS:

Continue with the planned programme of work and ensure the Integrated Medium- and Long-Term plans align to the delivery of the Digital Strategic Framework 2023-2027.

Continue with planning and reporting against the following:

1. **Enhance Clinical Practices and Patient Care:** In partnership with clinical services Conduct comprehensive analyses of performance dashboards to identify opportunities for the improvement of clinical practices and patient care through modelling digital solutions. This will be measured by the number of identified opportunities and their subsequent implementation.

2. **Monitor Digital Tool Utilisation:** Monitor the utilisation of digital solutions through the Clinical Systems Board, such as digital dictation and Civica E-Scheduling, via license usage dashboards to ensure accountability in the investment and effective use of digital technologies. Success will be measured by the percentage increase in digital tool usage and reduction in inefficiencies.
3. **Address Inefficiencies:** Investigate persistent inefficiencies, such as high volumes of printing despite the implementation of print management solutions and facilitate collaborative discussions to address these challenges. The goal is to reduce printing volumes by a specific percentage within a set period. This will be reported via the newly implemented Benefits Framework and toolkit.
4. **Focus** on digital projects that align with strategic priorities, enhance patient safety, and provide measurable benefits for patients, staff, and the organisation. Measure success by the number of prioritised projects and their completion rate.
5. **Improve Customer Satisfaction:** Continuously review the support experience across client services teams by standardising processes, improving documentation, and speeding up activities that impact the customer experience. Success will be measured by an increase in customer satisfaction scores.
6. **Enhance Cyber Security:** Maintain a high security posture by routinely remediating software vulnerabilities and addressing external audit findings. Progress will be measured by the number of vulnerabilities remediated and improvements in external audit reports.
7. **Upgrade Network Infrastructure:** Continue with network infrastructure improvements to increase capability, reliability, and throughput. Success will be measured by the completion of these projects within the set deadlines and the resulting improvements in network performance.
8. **Improve Data Quality:** Conduct an Intelligence Mapping review to add meaning and insights to the data being collected and held by the Health Board. The goal is to shift from a reactive to a proactive environment to enhance patient care, measured by the completion of the review and the implementation of its recommendations**.**
9. **National Programme Updates**: Progress with the Digital Maternity Programme, Electronic Prescribing Medicines Administration (EPMA), and the Welsh Community Care Information System (WCCIS) replacement. This will be measured by the number of users of national programmes and their successful phased completion**.**

Report the Digital First Updates to the Delivery and Performance Committee as scheduled to provide assurance on progress, challenges, and areas for improvement.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Appendix A – KPI Report May 25.

Digital Technology Key Performance Indicators

May 2025

Contents

Report Introduction

This report provides a comprehensive overview of service levels and compliance in managing digital services. It details various aspects, such as service level targets, overall compliance in handling requests and incidents, and compliance breakdowns by team. The document also examines top incident-generating services and user experience monitoring.
The goal is to monitor and improve the efficiency and effectiveness of digital service management.
The report is aimed at managers who want to understand how the demand on and performance of the Digital Services team could impact their team.

Executive Summary

The report shows May was average. Call numbers and waiting times at the Service Desk have improved significantly. There is data to suggest that repeat calls in March and April were behind wait times been driven higher.
SLA compliance for March has again exceeded the 90% target for requests. However, further analysis suggests a discrepancy with the quoted figure. There will be future work to improve this discrepancy, but overall SLA compliance has improved for requests.
Laptops and PCs continues to be a top cause for incidents. Deeper analysis of the tickets is showing improvements to be made to the quality of data being collected.
Recurring issues with Outlook are impacting senior managers when their recoverable items is filled up.
Overall, users appear satisfied with the service they receive. This month is the first time the satisfaction reaches 90%.

Digital Tickets

Tickets are used to structure, prioritise, and track work completed by the Digital Services. These tickets are generated through several methods:

- Email – An email is received from a staff member or supplier that generates a new ticket (this does not include emails that are matched to existing tickets)
- Portal – A ticket is created by using the forms on https://powysthb.haloitsm.com/portal/home
- Auto – A ticket is created automatically by Halo as part of an automated ticket process i.e. tickets in the New User Process, kit installation requests after equipment has arrived
- Manual/Phone – These tickets are created by a member of the team, usually by the Service Desk.

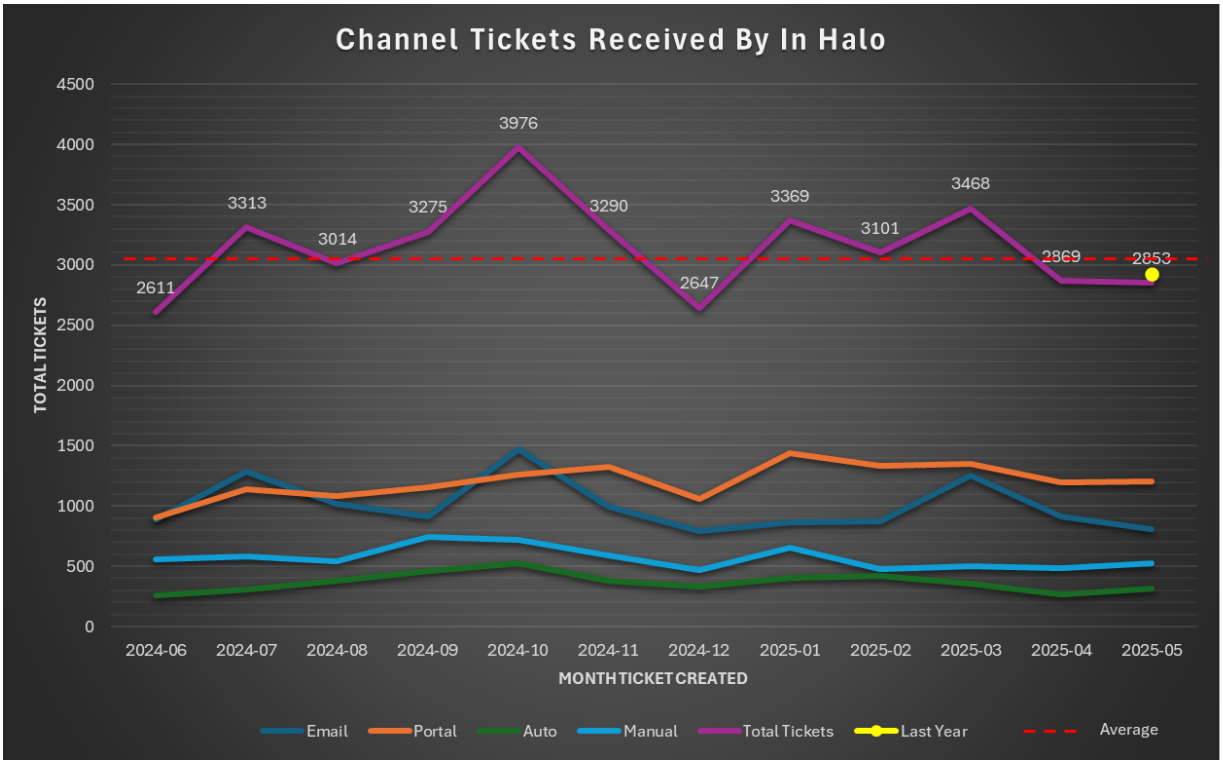


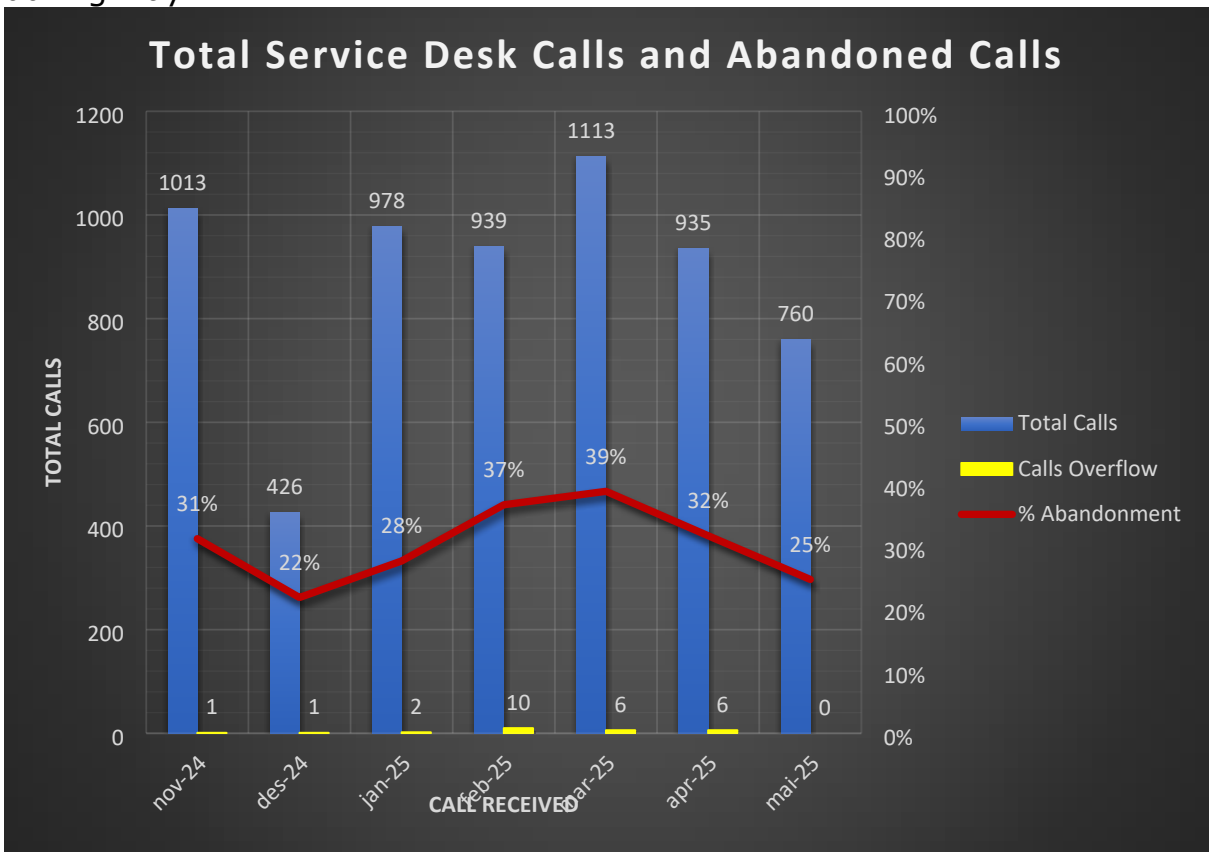
Figure 1 - Ticket generation by method the ticket was received.

The graph above depicts the number of tickets and the method by which they were received.
In May, the total number of tickets created was the same as April. There was a -0.6% difference.
The steady decline in portal tickets has stopped this month, with 0.9% more tickets via the portal. There were 13.5% less tickets via email.

Service Desk Calls

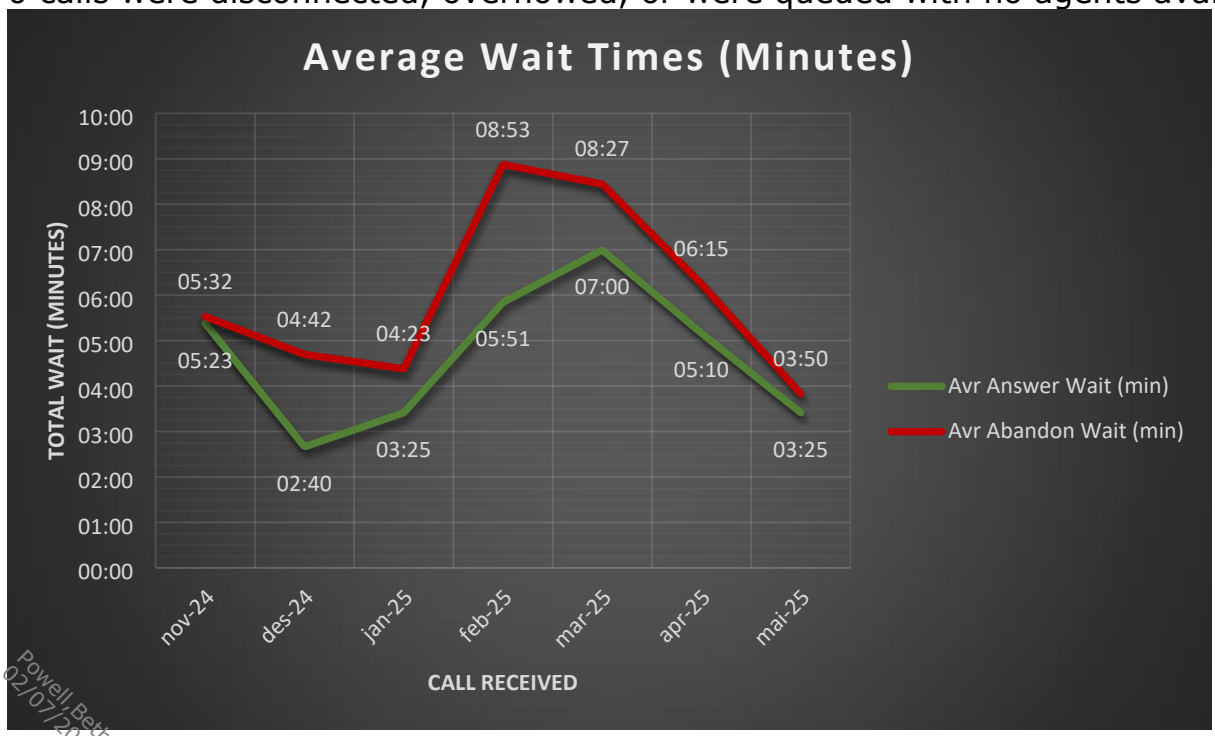
The following graph presents call volumes. Modifications have been applied to the graph to enhance the visual representation of call abandonment relative to the total number of calls.

This month, the team was back to full strength with only 1 week of annual leave during May.



In April, Service Desk calls fell by 18.7%, and abandonment rates decreased by 7%.

0 calls were disconnected, overflowed, or were queued with no agents available.



This month saw the average wait time decrease by 33.9% to 3 minutes and 25 seconds.

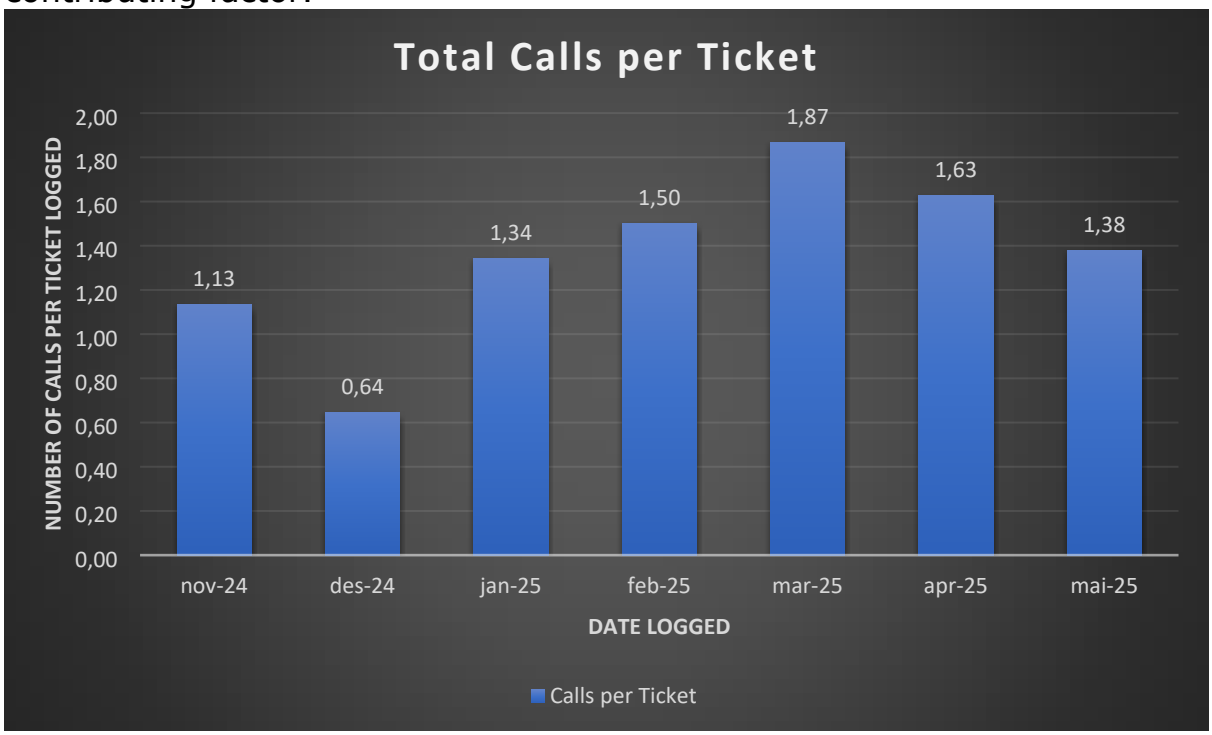
The wait times before answer are within the 2-3 minute targets set by Operational Level Agreements (OLAs) and Service Level Agreements (SLAs) with Health and Care Research Wales (HCRW).

Implications

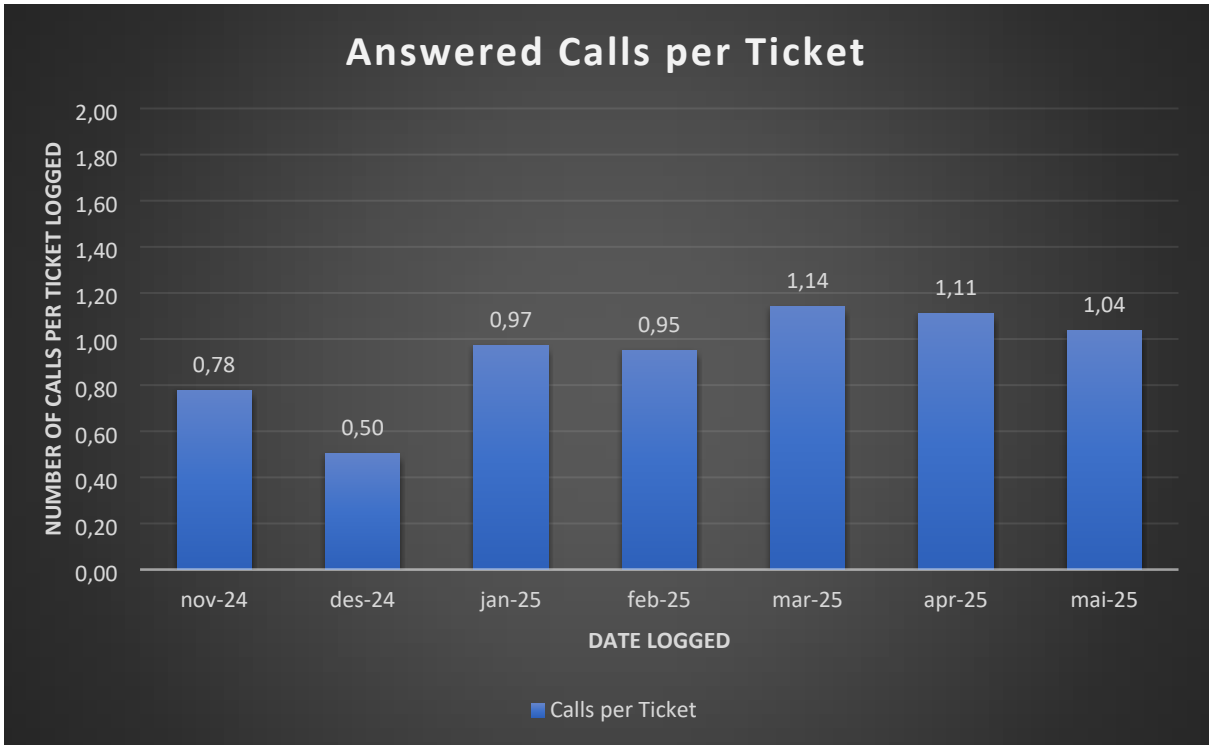
There appears to be a notable correlation between the abandoned wait time and the answered wait time, suggesting that callers may intuitively gauge the average answer time. Ideally, we would anticipate a more uniform baseline reflective of staff response times.

Our hypothesis posits that the average abandon wait time is influenced by staff terminating calls and attempting again with progressively longer wait periods. This behavior potentially elevates the average waiting time as more staff extend their waiting duration. However, such actions increase the load on the phone system, thereby reducing the likelihood of calls being answered promptly by an agent.

We have conducted an analysis comparing the number of calls received with the number of tickets logged manually in Halo. The resulting ratio exhibits a similar correlation with the trend in average wait times, indicating that this may be a contributing factor.



This trend can then be compared to the number of tickets generated per answered call. This approach aims to eliminate the influence of calls made to follow up or escalate tickets. If the trends between the two graphs are similar, our hypothesis is proven incorrect.



The graphs show a similar trend visually, but the differences between January to May are minimal in the second graph compared to the first graph. This variance suggests a factor is present that is causing a variance in call numbers against tickets logged. This suggests staff are repeatedly calling the Service Desk. Our theory is that this is flooding the phone system and staff are choosing to wait longer each time.

Without further investment in the service, we need to encourage users to use the portal to log tickets rather than generating demand through phone calls. Otherwise, staff are decreasing their chances of getting through by calling more often.

Incident & Request Trending

Service Requests range from requests for new equipment and software licences, to information requests.
Incidents indicate a failure, fault or problem with our digital services that impacts staff productivity or their ability to deliver care.
Both these ticket types represent a productivity cost to the health board and efforts are required to ensure the total number is reduced as well as the total time it takes to resolve them.

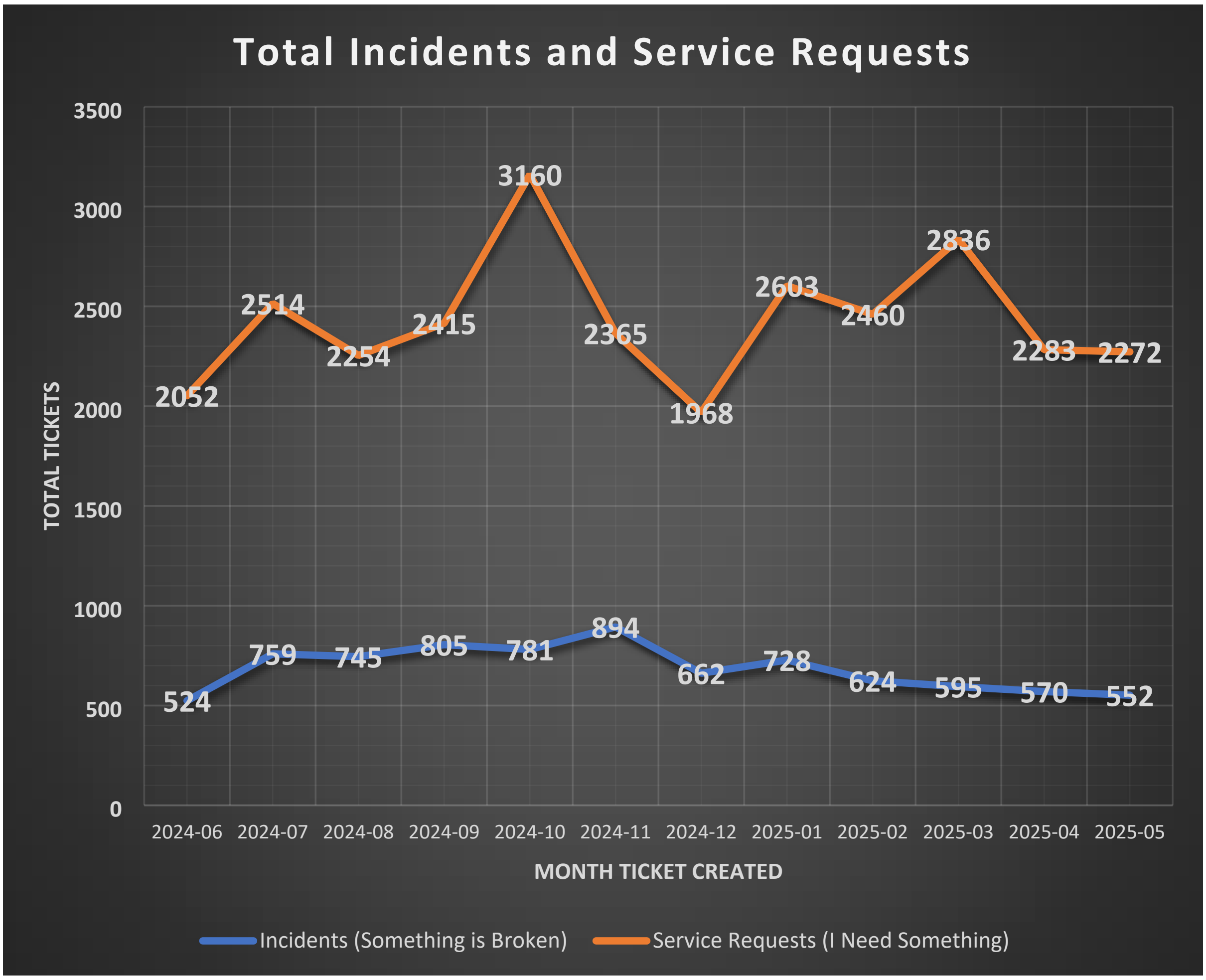


Figure 2 - Total incidents and requests by month

Service Requests Trends

Service requests outnumber incidents in the health board. The total number of service request was the same as April.

Incidents Trends

The number of incidents continues to fall, with a further drop of 4%. This is a total decrease of 24% since January.

Our aim is to reduce the frequency of incidents over time. We'll look to achieve this by: -

- Maintaining sustained investment in the removal of legacy infrastructure and client devices from our estate.

- Continue the expansion of automatic problem detection and remediation. Fixing problems before users are even aware of them.
- Sustained efforts to remove single points of failure in our infrastructure and digital services.

The data indicates that current efforts have successfully curbed the rise in the number of incidents and that we are in fact reducing the likelihood of an incident occurring.

Service Level Targets

Digital Services set the following service response targets.

Requests

Priority	Resolution Target
Expedited Request	3 Days
Standard Request	5 Days
Low Priority Request	10 Days

Incidents

Criticality	Response Target	Resolution Target
Emergency Healthcare Impact across Health Board	1 Hour	2 Hours
Critical Healthcare Impact at a single site	1 Hour	4 Hours
Major Departmental Impact	2 Hour	8 Hours
Normal User Impact	4 Hour	12 Hours
Low Limited Impact / Annoyance	8 Hour	16 Hours

In April, the Applications Team and WCCIS teams were merged in our ITSM and now function as a single team, Clinical Applications. A third line team, System Architecture & Integration, was created to mirror changes in staffing structure and provide an escalation route from Clinical Applications.

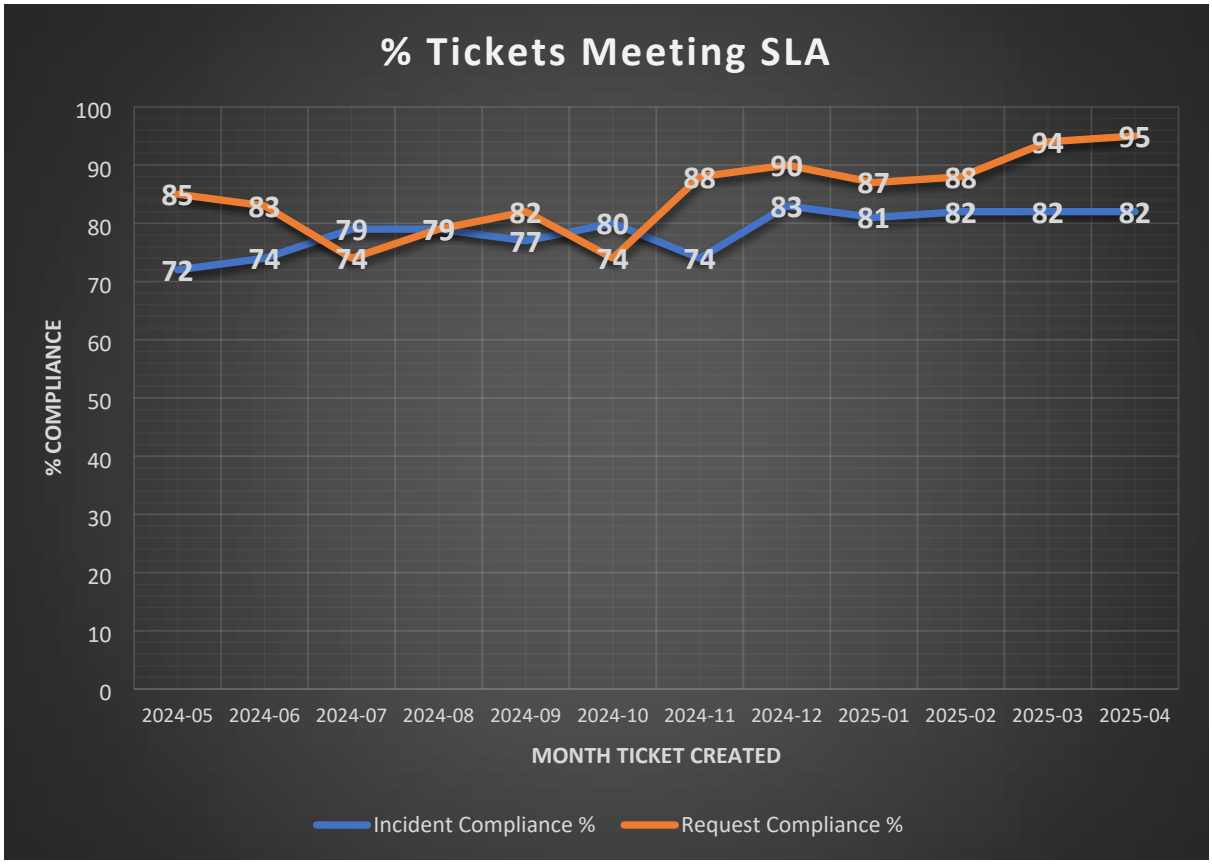


Figure 3 - SLA compliance by ticket for tickets closed as of 3rd June.

Variation in previously reported SLA rates is within +/- 1%.

Requests Overall Compliance

Compliance in March rose to 95%. Further analysis of SLA rates by team do not concur with the figure being quoted. Our estimation is the compliance is ~91%, though this figure is still above the 90% target for the service.
More time is needed to root cause the discrepancy in these numbers.

Incidents Overall Compliance

Compliance in March has been maintained compared to the previous 4 months. There is no discrepancy with this quoted figure.

Request Compliance Breakdown by Team

The graph below shows the level of compliance by different teams in the Digital Services. Compliance is not consistent across the teams, possibly identifying gaps in resource to meet demand within the set SLAs.

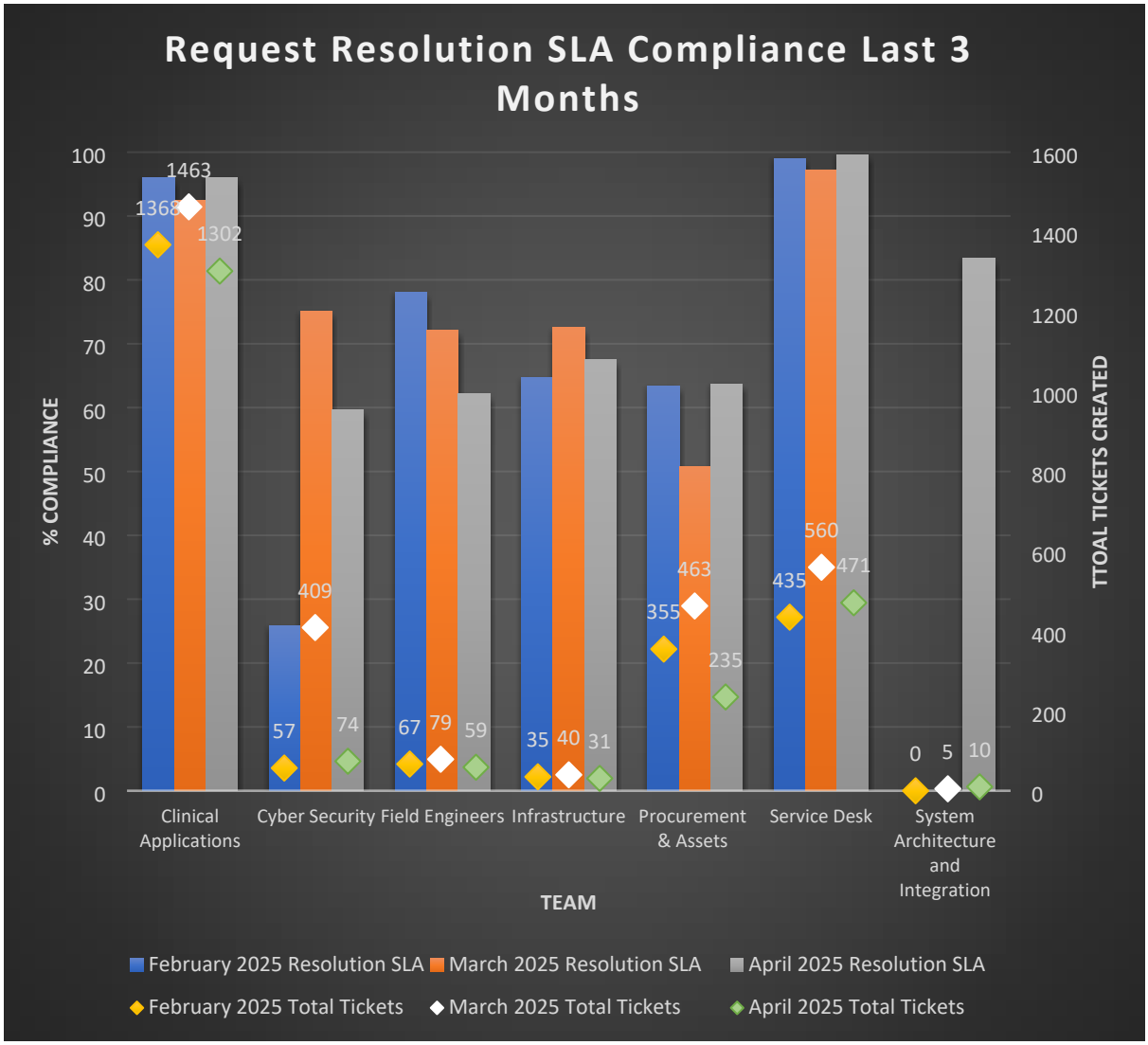


Figure 4 - Request SLA Compliance by Team for the last 3 months

SLA Achievers (>90%)	Notable improvements in SLA (+10%)	Non Compliant (<90%)
• Clinical Applications • Service Desk	• Procurement & Assets	• Cyber Security • Field Engineers • Infrastructure • System Architecture and Integration

Both Clinical Applications and Service Desk met their SLA targets, with Clinical Applications resolving 1302 requests.
Cybersecurity saw a drop in SLA despite receiving less tickets. However, this will be due to the ease of bulk closing a single issue in March (phishing training) compared to a varied request type in April.
Procurement & Assets saw a 13% increase in SLA compliance. This was achieved for two reasons:

1. There were half as many requests created with the team

2. The backlog of tickets had been significantly reduced by utilising stocked items that arrived in March

Both the Infrastructure and Field Engineer teams did not meet the SLA target and saw decreased in compliance despite less tickets. Work is ongoing in both teams to improve their ticket management.

Incident Compliance Breakdown by Team

The graph below illustrates the compliance levels of various teams within Digital Services. There is a noticeable inconsistency in compliance across these teams, potentially highlighting resource shortages to fulfil demand within the established SLAs.

The Incident Response SLA refers to the time taken for a team to acknowledge receiving an incident reported via email or the portal. At this stage, the incident is prioritised and forwarded to the appropriate team, which must resolve the ticket within the resolution SLA.

The Incident Resolution SLA is the time taken for a team to resolve the issue reported. At this stage the ticket has been triaged. The total resolution time is the time that the team can provide a fix. If the ticket is escalated to a supplier or a meeting is arranged to discuss the issue, then the timer is placed on hold.

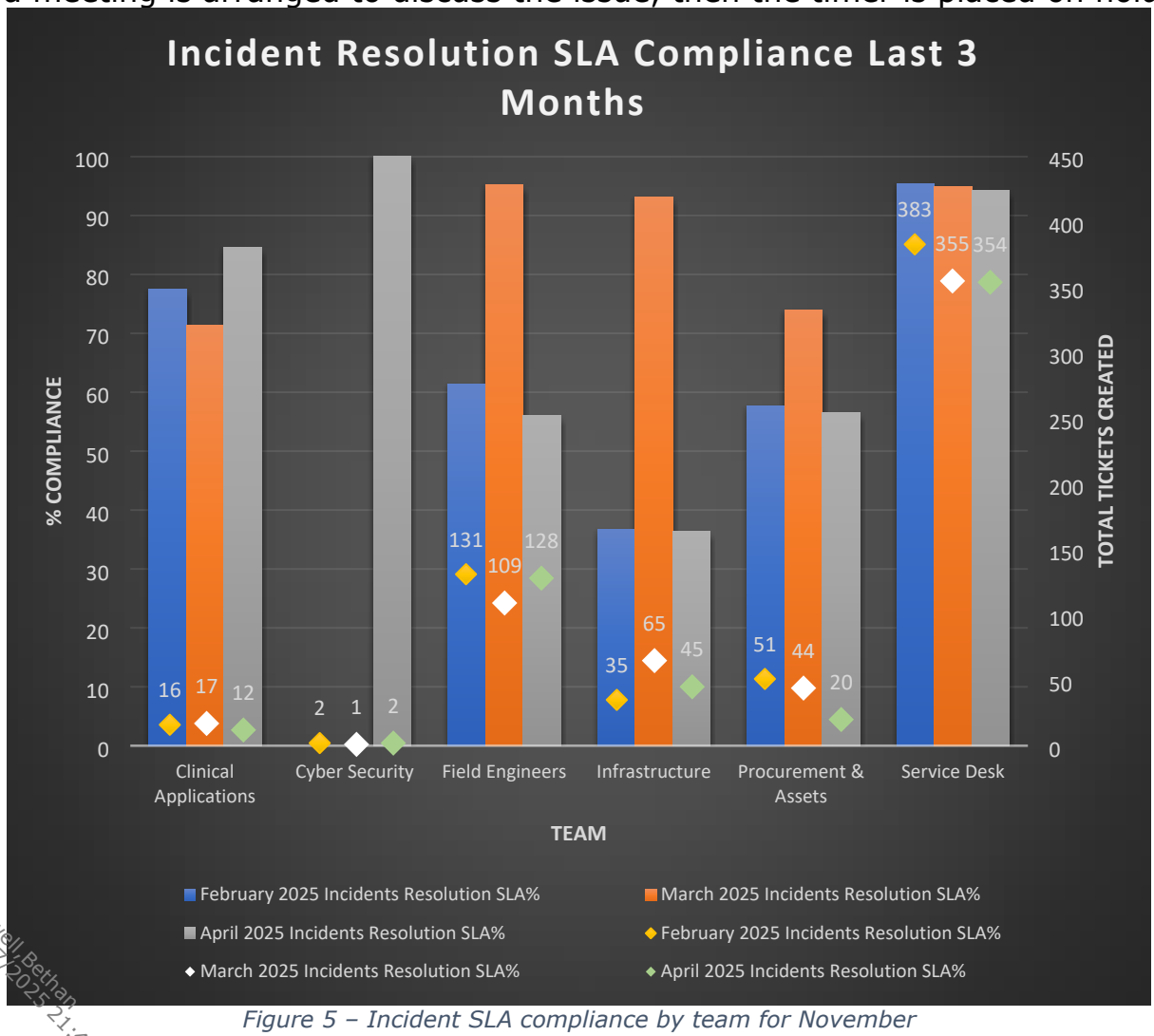


Figure 5 – Incident SLA compliance by team for November

SLA Achievers (>90%)	Non Compliant (<90%)
• Service Desk • Cyber Security	• Clinical Applications • Infrastructure • Field Engineers • Procurement & Assets

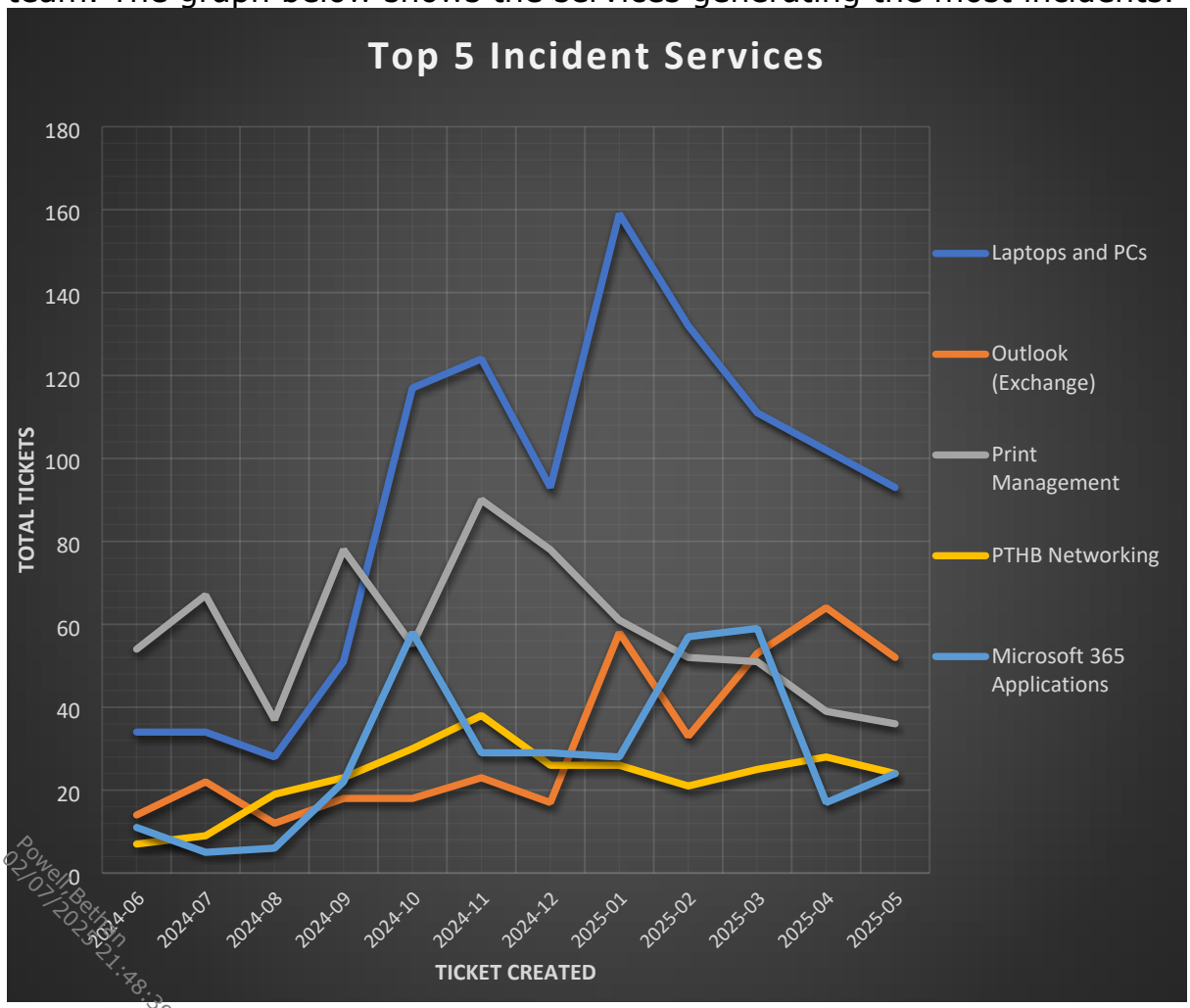
Apart from Cyber Security and Service Desk, all teams did not meet their SLA targets for resolving an incident. Previous gains in March were not maintained during April. This maybe influenced by annual leave during the Easter holidays. Service Desk compliance remained high in April.

Implications

Some teams face demand and capacity issues that hinder compliance. Improvements have been made in the ITSM to allow agents to easily correct triage mistakes and ensure the right SLA is being applied. These changes need more time to bed in.

Top Incident Generating Services

Identifying the services that cause incidents helps us target issues impacting our team. The graph below shows the services generating the most incidents.



Laptops and PCs

25% of the tickets involved damaged equipment, performance issues, or operating system problems, usually requiring a new device or re-imaging. No particular device model showed frequent failures. This month, ticket profiles shifted from driver and Windows 11 upgrade issues to tickets related to another service, merely because staff were using laptops or PCs.

Outlook (Exchange)

Five senior staff members faced issues because their recoverable items exceeded 100GB. This problem is recurring amongst this staff group and solutions are not immediate.

A recurring issue with the new Microsoft Outlook presents an unknown error when starting. Repairing the installation resolves this but requires Service Desk assistance.

Other errors appear transient and can be fixed by restarting the machine or waiting for synchronisation between different Outlook versions, especially when switching from the classic version to the new one.

Print Management

On the afternoon of May 22nd, a general failure of the scanning solution occurred and was fixed by 09:15 on May 3rd. An unknown issue with the PaperCut servers is causing recurring issues. Investigations by Apogee have included increasing logging to determine the root cause. In the meantime, alternative solutions such as recurrent restarts are being considered to mitigate the issue occurring.

Another issue on May 2nd involved a PaperCut server not responding, resolved by restarting it. Only two tickets were reported.

Various other tickets relate to general printer issues. One example is old printers no longer working due to the old infrastructure being turned off, with the Field Engineer restoring functionality instead of arranging removal. This has been raised with the Client Services Lead to support staff with removing devices.

PTHB Networking

Ticket information lacks patterns or clear root causes. Agents often don't detail what caused the incident and only state that it is resolved. Many tickets are wrongly labelled as PTHB networking issues. These concerns are being escalated to the Infrastructure team lead.

Microsoft 365 Applications

Many of the ticket related with the service were incorrectly tagged, falsely inflating the position of the service.

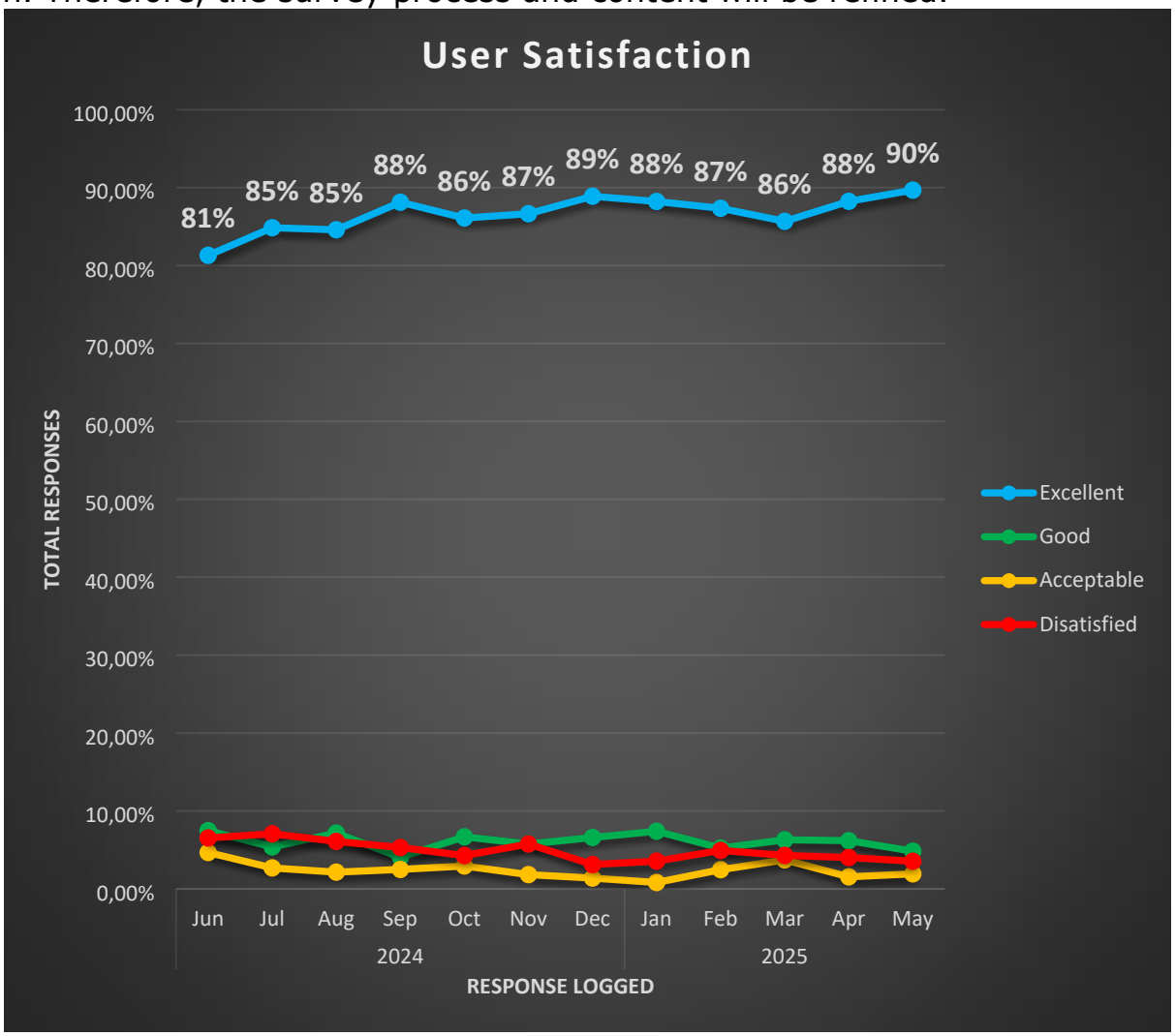
Feedback has been provided to the Client Services Lead to improve the services being selected.

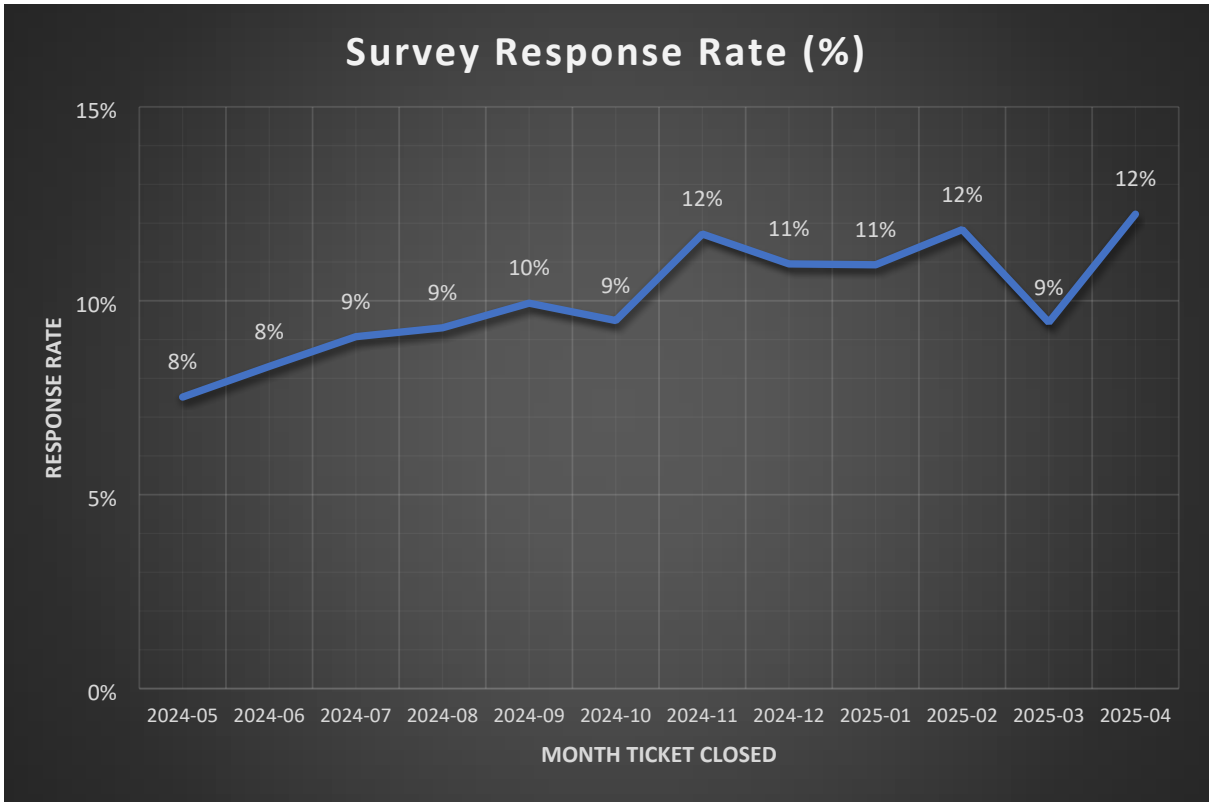
User Experience Monitoring

Digital Services are keen to ensure that any interaction with us is positive, and a such we offer staff to provide feedback on their experience throughout their ticket being resolved.

The data below demonstrates that most members of staff who took the time to rate their experience with digital as positive. For the first time, the user satisfaction has reached 90%.

This month, team leads for Service Desk, Procurement & Assets, and Clinical Applications have been testing a new "Dissatisfaction" feature. This feature creates a ticket for review when dissatisfaction is reported. However, some tickets receive multiple ratings because users can report satisfaction multiple times. While this data is valuable, there is limited capacity to manage it as tickets come in. Therefore, the survey process and content will be refined.





Some examples of feedback:

Excellent
Amazing support as always, nothing is ever too much trouble. Llinos you have the patience of a saint . Thank you
Andrew and Rob ICT, were amazing setting up a printer access at DHCW, when you work for HCRW PTHB as in, a different health board to the equipment you need access, is not a simple process, and could have been a nightmare for me. They coordinated with DHCW and everything came together perfectly. Very happy.
Great work downloading the app for me to use for Visio carried out by Rob (D)

Dissatisfied
This child unfortunately is not open to our service and if she is I am not able to access our department information to carry out their ongoing care. Please can this e reviewed. *Kind Regards*
failure to address service critical issue.
solved this time but we have no direction when it happens again to sort it. This problem is reocurring.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.9

Audit, Risk and Assurance Committee	**Date: 08 July 2025**
Subject:	**Risk Management and Board Assurance**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Strategic Risks – PTHB Board 21 May 2025
Appendices:	Appendix A – Board Assurance Framework Dashboard (example)

PURPOSE:

This report provides the Committee with the risks due to be allocated to the Committee for oversight following presentation to the Board in May 2025.

An update is also provided on the development of the new Strategic Risk Register and Board Assurance Framework Dashboard, which are both due to be presented to the Board in July 2025.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** that the Strategic Risk Register (SRR) is currently under development and **RECEIVE** an overview of the risks due for allocation to this Committee for oversight following endorsement in July 2025;
- **RECEIVE** and **DISCUSS** the proposed templates developed for the Board Assurance Framework Dashboard from July 2025.

Approve/Take Assurance	Discuss	Note
√	x	x

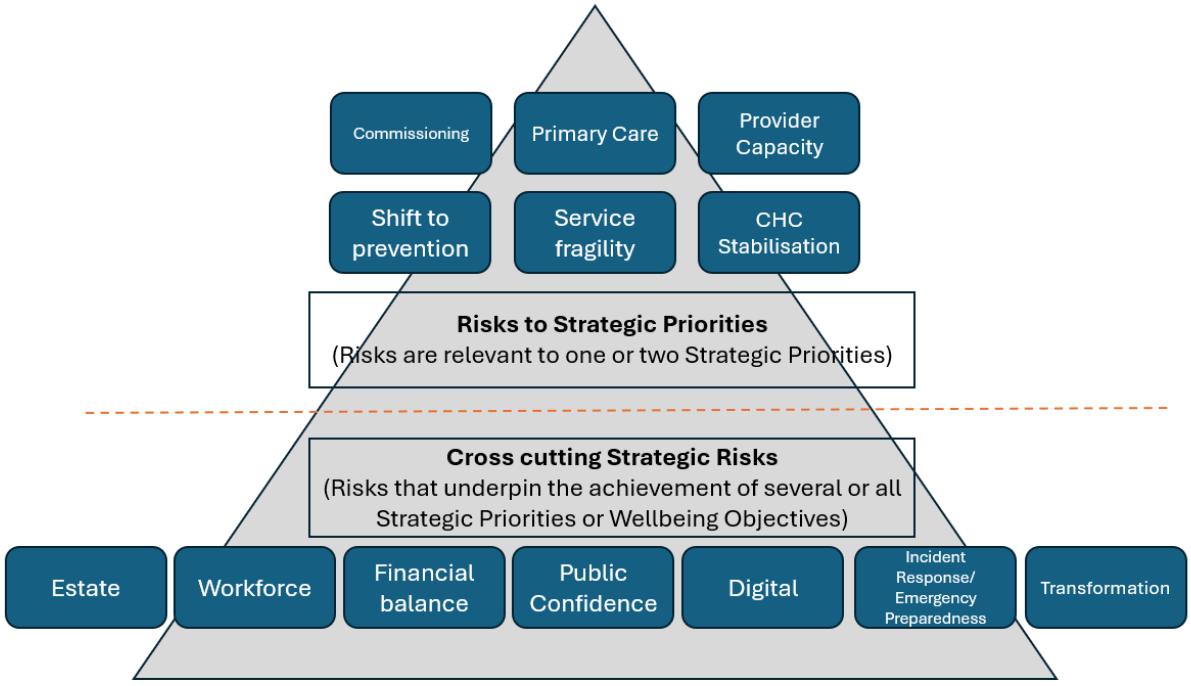
ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The corporate risks are a reflection of the significant risks to the delivery of the health board's strategic objectives and therefore underpin all wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

STRATEGIC AND COMMITTEE RISK REGISTERS

In March 2025 the Board approved a revised Risk Management Framework (RMF). The key fundamental change within the revised framework was the closure of the Corporate Risk Register (CRR), to be replaced with a Strategic Risk Register, owned by the Board and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk, owned by the Executive Committee.

Following approval of the revised RMF, the Corporate Governance Team has been working closely with the Board, individual Executive Directors and Assistant and Deputy Directors to develop the new SRR.

On 21 May 2025, an update on progress was reported to the Board which provided a summary of the identified risks to the delivery of the Health Boards Strategic Priorities and their associated risk descriptors. It was noted that some of these risks had been identified as 'cross-cutting' (underpinning the achievement of several or all Strategic Priorities or Wellbeing Objectives) and risks to Strategic Priorities which were relevant to one or two of the Strategic Priorities identified within the Health Board's Integrated Plan. An overview of this update is provided below:



The proposals were supported by the Board on 21 May 2025 and work is now nearing completion to develop a fully detailed SRR for presentation to the Board in July 2025.

Committees of the Board who are allocated Strategic Risk(s) by the Board routinely receive a Committee Risk Register, which draws together the relevant risks from

the SRR to provide a summary of the significant risks to the Health Board within the Committee's remit.

Whilst in development the following risks have been identified as falling within the Audit, Risk and Assurance Committee's remit for scrutiny and oversight on behalf of the Board. Please note the information provided below remains in draft and should therefore be considered as subject to change:

Risk Reference and Title	Description	Current Score (Draft): likelihood x impact
SRR 012 – **Digital**	There is a risk that the Health Board has inadequate digital infrastructure and systems to deliver safe, high-quality services	Scoring TBC

The full Committee Risk Register will be reported to the next meeting of the Committee on 7 October 2025.

BOARD ASSURANCE FRAMEWORK DEVELOPMENT

In May 2024 the Board approved a revised Board Assurance Framework (BAF), recognising that the BAF is a complex system comprising of a number of key systems including:

- Risk Management Framework
- Quality and Performance Framework; and
- The overall system of governance deployed by the Board and the Chief Executive in ensuring good governance within the organisation.

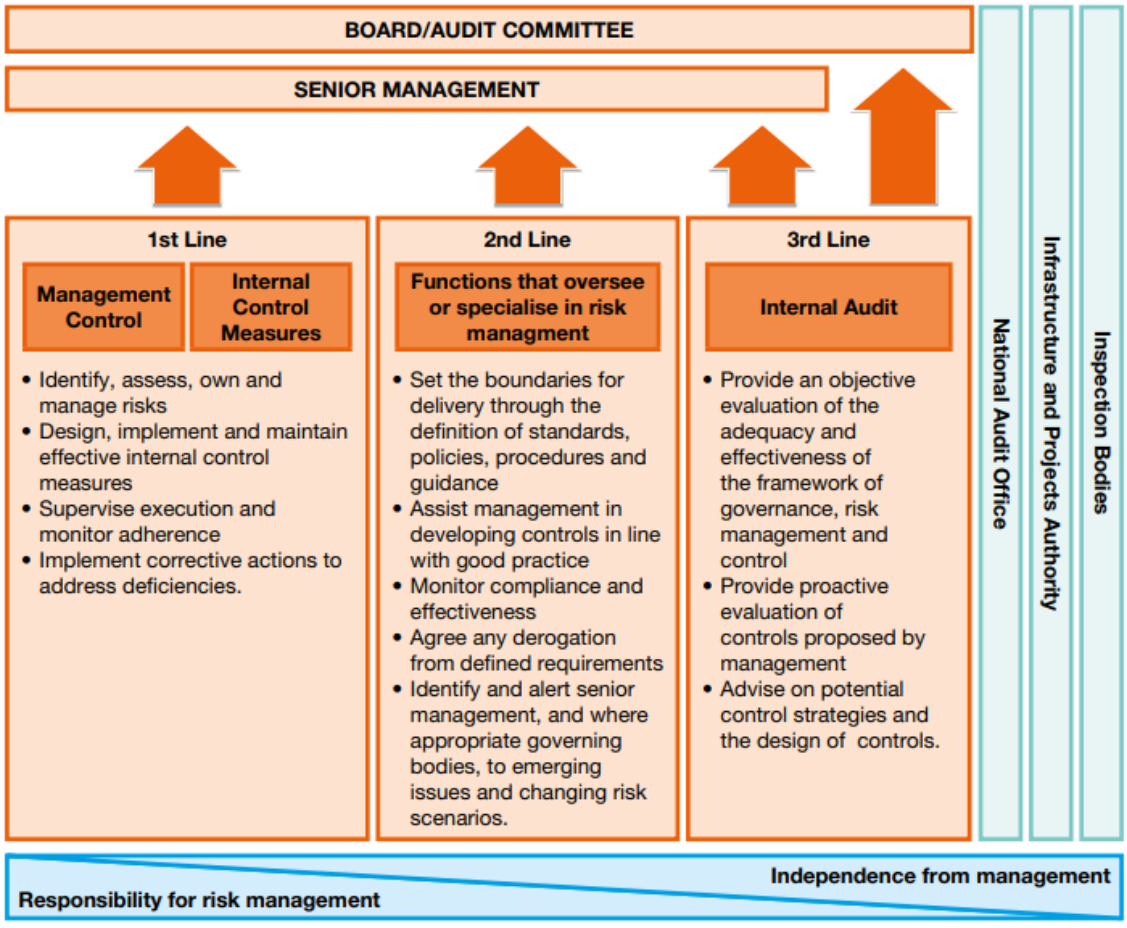
The purpose of the Board Assurance Framework (BAF) is a structured means of identifying and mapping the main sources of assurance in the organisation, and co-ordinating them to best effect. It is intended that through appropriate utilisation of the BAF, the Board can have confidence that it is providing thorough scrutiny of its role and is able to identify any gaps in assurance and take appropriate action as a result.

Following approval of the RMF in March 2025, work has been underway to develop a BAF Dashboard in support of the Health Boards SRR, as indicated in the last update provided to the Committee in October 2024. This BAF Dashboard is under development and will support the Board's SRR and will 'close the loop' of the risk management process. Seeking/providing assurance that the actions deployed by the Board to manage/mitigate its key risks are adequate and effective, and presenting an opportunity to undertake further action where gaps or weaknesses are identified. This dashboard will therefore be a key reporting mechanism in terms of both the BAF and SRR.

As mentioned, the dashboard will focus on providing assurance in relation to the adequacy and effectiveness of the controls currently deployed by the Health Board to mitigate/manage its strategic risks and will demonstrate a summary of the findings of associated available assurance. This will provide a key opportunity of the Executive Committee and Board to focus on key improvement areas.

The template developed for the BAF Dashboard is included within this paper as Appendix A. When the Strategic Risk Register has been fully developed the risk information will be utilised to populate the BAF Dashboard template. The dashboard will then be reported to the Executive Committee and Board alongside the SRR.

Sitting behind the BAF Dashboard will be a detailed Risk Assurance Analysis for each strategic risk, which will provide an overview of controls, gaps or weaknesses in controls, including the balance of reaction vs proactive controls and will list the associated assurance available in relation to the controls for each risk. As the BAF continues to mature throughout 2025/26, work will be undertaken to review the Risk Assurance Analysis in relation to each risk in line with the Orange Book (2023)'s Three Lines Model (included below) to ensure the assurance available/reported to the Board in relation to its strategic risks is sufficiently balanced and appropriate in accordance with the model.



The Committee is asked to consider the proposals for the BAF Dashboard and provide any feedback for integration into the approach in readiness for population and presentation to the Executive Committee and Board.

NEXT STEPS:

The newly developed Strategic Risk Register will be presented to the Board on 30 July 2025, following review by the Board, the Committee will receive an update on the Committee Risk Register (those risks within the Strategic Risk Register allocated to the Committee) to each meeting for scrutiny and assurance.

The Committee is asked to discuss the proposals in relation to the format and information proposed for inclusion within the Strategic Risk Register and Board Assurance Framework and provide any feedback to the Director of Corporate Governance/Board Secretary.

The Strategic Risk Register and Board Assurance Framework Dashboard will be reported to the regularly to the Board, when established, any updates made to risks will be indicated by the use of red font. Detailed Risk Assurance Analysis for each risk is also under development which will report to the Board twice annually. The Corporate Governance Team will continue to take steps strengthen and mature and Risk Management Framework and Board Assurance Framework via a process of continuous improvement.

Board Assurance Framework (BAF) Dashboard

Draft Example for Audit, Risk and Assurance Committee

Board Assurance Framework Dashboard: Key

Key:

Adequacy of Controls	Effectiveness of Controls	Control Assurance
Are we doing enough to manage the risk?	*Is what we're doing working?*	*Based on what evidence?*
GREEN: Multiple controls	GREEN: Controls largely effective	GREEN: Assurance largely substantial
AMBER: Some controls	AMBER: Some control weaknesses	AMBER: Assurance largely reasonable
RED: Limited/no controls	RED: Significant control weaknesses	RED: Assurance largely limited
		GREY: Insufficient assurance available

⚠ Risk outside Board appetite

2

Board Assurance Framework Dashboard

Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls *Are we doing enough to manage the risk?*	Effectiveness of Controls *Is what we're doing having the desired impact?*	Associated Assurance *What is the available assurance telling us?*
SRR 001: **Financial Balance** *EDoFC&E*	**20**	**20**	**8**	⚠	Multiple Controls	Some control weaknesses	Assurance largely Reasonable
SRR 002: **Transformation** *EDP&C*							
SRR 003: **Commissioning** *EDPP&C*							
SRR 004: **Provided Services** *EDPCCMH*							
SRR 005: **Primary Care** *EDPCCMH*							
SRR 006: **Workforce** *EDP&C*							

COMPLETED AS EXAMPLE ONLY

Strategic Risk	Inherent Score	Current Score	Target Score	Within Appetite	Adequacy of Controls *Are there enough controls in place?*	Effectiveness of Controls *Are those controls working as intended?*	Associated Assurance *How do we know/evidence?*
SRR 007: **Estate** *EDoFC&E*							
SRR 008: **Prevention** *EDPH*							
SRR 009: **Continuing Health Care** *EDPCCMH*							
SRR 010: **Emergency Preparedness/Incident Response** *EDPH*							
SRR 011: **System Resilience** *EDPCCMH*							
SRR 012: **Digital** *EDAHPHS&D*							
SRR 013: **Public Confidence** *DCG*							

Summary Position

- X of 13 Risks are operating within the Board's Risk Appetite
- X of 13 Risks are operating outside of the Board's Risk Appetite
- *Is the Executive Committee/Board willing to tolerate the current position outside of appetite or is action to identify and implement further controls needed to mitigate risks?*
- X of 13 Risks Inherent Scores are the same as Current Scores, suggesting a need to review the effectiveness of controls.
-

Scoring Matrix

Likelihood x Impact = Risk Score

LIKELIHOOD						
	Almost Certain 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Possible 3	3	6	9	12	15
	Unlikely 2	2	4	6	8	10
	Rare 1	1	2	3	4	5
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
		IMPACT				

Risk Appetite Summary

Summary overview of risk appetite in relation to strategic risks to be developed and included following Board approval of 2025-26 Risk Appetite Statement

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.10

Audit, Risk and Assurance Committee	**Date: 08 July 2025**
Subject:	**Committee Effectiveness: Continuous Improvement Plan 2025-26**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A
Appendices :	Appendix A – ARAC Continuous Improvement Plan 2025-26

PURPOSE:

This report provides the Committee with a plan for continuous improvement, based upon the matters identified for actions within the 2024-25 annual review of Committee effectiveness.

The plan comprises of actions arising from and relevant to all Committees (Cross Committee Action Plan) and those actions which are specific to the Audit, Risk and Assurance Committee.

RECOMMENDATION(S):

The Committee is asked to:

a. **RECEIVE** the ARAC Continuous Improvement Plan 2025-26 and **TAKE ASSURANCE** that the implementation of continuous improvement actions will be monitored throughout the year as a key principle of good corporate governance.

Approve/Take Assurance	Discuss	Note
x		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	A commitment to good governance and robust corporate systems are a key enabler of all of our wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	

6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

COMMITTEE EFFECTIVENESS

Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous improvement.

The approach for 2024/25 comprised of a a questionnaire followed by discussion at the Committee. The Committee effectiveness questionnaire focused on the critical themes of:

(i) composition and establishment
(ii) effective functioning
(iii) assurance and
(iv) leadership and culture

The findings of the Audit, Risk and Assurance Committee review were received and discussed by the Committee on 13 May 2025, and subsequently the findings of all Committees were combined and reported to the Chair's Forum and the Board.

A key aspect of the effectiveness review is the formulation of actions based upon identified opportunities for continuous improvement as part of the process.
The Corporate Governance team has undertaken a thematic review of all Committee Effectiveness review findings both holistically for all Committees and for each Committee individually and has pulled out the key actions to enable continuous improvement for implementation throughout 2025-26.

Actions have been identified as either Cross-Committee actions (improvement opportunities/actions arising identified by and/or relevant to all Committees of the Board) or Committee specific actions, identified by and/or relevant to a single Committee.

Implementation of the Continuous Improvement Plan 2025-26 (Appendix A) will be monitored by the Corporate Governance team, and will return to the Committee regularly for assurance.

NEXT STEPS:

The Corporate Governance Team will continue to monitor implementation and will provide a further update on progress to the meeting on the Committee 10 March 2026.

Appendix A – ARAC Continuous Improvement Plan 2025-26

Committee Effectiveness: Continuous Improvement Plan 2025–2026 (Draft and subject to Board review)

Audit, Risk and Assurance Committee

Cross-Committee Action Plan (actions relevant to all Committees)

Theme	Action	Owner	Timeline	Status	Comments
Membership	Review and confirm committee membership	DCG / PTHB Chair	Q1	Complete	New Committee Membership confirmed as of May 2025
Assurance to Board	Develop a standardised reporting template for clear upwards assurance	Governance Team	Q2	Complete	Alert, Advice, Assurance, Inform (AAAI) Reports have been introduced for all Committees for reporting to the Board from March 2025 (having been piloted during 2024/25). This template will be reviewed and matured in readiness for September Board.
Organisational Learning	Schedule opportunity to actively consider evidence of learning and improvement in each Committee	Governance Team	Q3	Not yet started	

Committee Agenda Focus	Apply risk-based approach to planning agendas, prioritising high-risk/high-impact items	DCG/Committee Chairs	Q1	Underway	Prioritisation is already undertaken as part of the agenda setting process, but check in will be integrated to consider the associated risk and impact of items
Training & Induction	Develop induction information and training needs analysis for each Committee	Governance Team	Q4	Underway	ARAC induction pilot scheduled for September 2025, other Committees tbc.
Integration of Risk	Incorporate risk lens in committee discussions and papers	Governance Team	Ongoing	Not yet started	

Committee-Specific Action Plans

Audit and Risk Assurance Committee (ARAC)

Theme	Action	Owner	Timeline	Status	Comment
Benchmarking and monitoring effectiveness	Use external benchmarks to help assess ARAC effectiveness annually	Governance Team	Q3	Underway	CG Team are in liaison with Audit Wales and other key partners to source and confirmed positive practice examples for sharing prior to the next effectiveness review
Level of focus on lower assurance audits and overdue recommendations	Develop agenda and papers to ensure proportionate focus on areas of most risk	Governance Team / Chair of Committee	Q2	Underway	Work underway to develop and improve focus of Audit Tracking and WHC reporting, consideration also being given to the use of the consent agenda for lower risk items
Training and Induction	Develop a specific training/induction process for ARAC Members	Governance Team supported by Chair of Committee	Q3	Underway	ARAC induction pilot scheduled for September 2025

Audit, Risk and Assurance Committees 2025-26

Theme	Item Title	Exec Lead	May 13/05/2025	June 17/06/2025 (Annual Accounts)	July 08/07/2025	Oct 7/10/24	Jan 13/01/2026	March 10/03/2026
Governance	Minutes of previous meeting	DCG	✔		✔	✔	✔	✔
Governance	Declaration of Interests	DCG	✔		✔	✔	✔	✔
Governance	Action Log	DCG	✔		✔	✔	✔	✔
Governance	Annual Work Programme	DCG	✔		✔			
Governance	Work Programme (updated through year)	DCG			✔	✔	✔	✔
Governance	Annual Assessment of Committee Effectiveness	DCG	✔					✔
Governance	Committee Governance Action Plan	DCG			✔			✔
Governance	Committee Annual Report	DCG	✔					
Governance	Audit Recommendation Tracker	DCG				✔		✔
Governance	WHC Tracker	DCG	✔			✔		✔
Governance	Register of Interests	DCG				✔		✔
Governance	Board Members Register of Interests and Register of Gifts and Hospitality	DCG				✔		✔
Governance	Board Assurance Framework	DCG				✔		
Governance	Review of Terms of Reference	DCG	✔					✔
Governance	Review of Standing Orders and Standing Financial Instructions	DCG						✔
Governance	Confirmation Clinical Audit Programme in place	EMD			✔			
Annual Accounts	Approach to the Annual Accounts	ED FC&SS/DCG						✔
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	ED FC&SS	✔					
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	ED FC&SS		✔				
Internal Audit	Head of Internal Audit Opinion Draft	DCG	✔					
Internal Audit	Head of Internal Audit Opinion Final	DCG		✔				✔
Internal Audit	Internal Audit Annual Plan	DCG						✔
Internal Audit	Internal Audit Progress Report 24/25	DCG	✔		✔	✔	✔	
Internal Audit	Internal Audit Reports (as required)	DCG	✔		✔	✔	✔	✔
Internal Audit	Internal Audit Trend Report	DCG					✔	
External Audit	Enquiries of Management and Those Charged with Governance	ED FC&SS/DCG		✔				
External Audit	External Audit Annual Plan	ED FC&SS/DCG						✔
External Audit	External Audit Progress Report	DCG	✔		✔	✔	✔	
External Audit	External Audit Reports (as required)	Lead	✔		✔		✔	✔
External Audit	Structured Assessment	DCG	✔				✔	
Counter Fraud	Counter Fraud Annual Plan	ED FC&SS						✔
Counter Fraud	Counter Fraud Update	ED FC&SS	✔		✔	✔	✔	
Counter Fraud	Counter Fraud Reports (as required)	ED FC&SS	✔		✔		✔	✔
Finance and Procurement	Single Tender Waivers Annual Report	ED FC&SS	✔					
Finance and Procurement	Single Tender Waivers (including extensions to contracts)	ED FC&SS	✔		✔	✔	✔	✔
Finance and Procurement	Losses and Special Payments Annual Report	ED FC&SS	✔					
Finance and Procurement	Losses and Special Payments	ED FC&SS	✔			✔		✔
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Jan	ED FC&SS	✔				✔	
Finance and Procurement	Financial Controls	ED FC&SS				✔		
Risk	Review of Risk Management Framework	DCG				✔		
Risk	Assurance of Risk Management arrangements inc. revised Risk Management Toolkit	DCG	✔		✔	✔		
Hosted Bodies	Hosted Body annual report (HCRW)	DWOD		✔				
Information Governance	IG Annual Report	DCG	✔					
Information Governance	IG Performance Report	DCG				✔		✔
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)	EMD			✔			
Information Governance	Information Governance & Records Management report	DCG	✔				✔	
Digital First	Digital First: annual deep dive into the Digital Programme	DoAHP,HS&D					✔	
Digital First	Digital First Annual Plan	DoAHP,HS&D				✔		
Digital First	Digital First Quarterly Monitoring (including cyber security)	DoAHP,HS&D			✔	✔	✔	✔

Key	Key:
Date to be confirmed	Date to be confirmed
Item to be confirmed	Item to be confirmed
Item deferred	Item deferred
Item brought forward	Item brought forward
Going to Board	Going to Board
Find Exec Cttee date	Find Exec Cttee date
Added to draft agenda	Added to draft agenda

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

Powys Teaching Health Board Glossary (June 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development

CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
H&S	Health and Safety

HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHLD	Mental Health & Learning Disability
MIU	Minor Injury Unit

MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment

RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.3

AUDIT, RISK AND ASSURANCE COMMITTEE	**08 JULY 2025**
Subject:	**Model Standing Financial Instructions**
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:

This paper seeks to outline the amendments to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards following the issue of the Welsh Health Circular 2025/012.

The Health Board is required to amend Model Standing Financial Instructions in relation to Chapter 11 Procurement and Contracting.

RECOMMENDATION(S):

The Committee is asked to

- **REVIEW** the paper and **RECOMMEND** the changes to the Board for approval.

Approve/Take Assurance	Discuss	Note
Y	N	N

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

REVIEW OF PTHB STANDING ORDERS

The Model Standing Financial Instructions form part of the Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business.

When agreeing SOs, LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers. These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB. The Standing Orders of the organisation were last amended in May 2024.

The current Standing Financial Instrcutionss are available using the link here - Board Approved May 2024 Schedule 3 Standing Financial Instructions

Following receipt of Welsh Health Circular 2025/012 Chapter 11 of the Model Standing Financial Instructions have been superseded by new Model Standing Financial Instructions for Procurement and Contracting which are attached at **Appendix A.**

NEXT STEPS:

The revised Model Standing Financial Instructions will be taken to Board for approval following which the revised version uploaded to the Health Boards website.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

11. PROCUREMENT AND CONTRACTING

Any instruction or summary of legislation in this chapter of the Local Health Board's (LHB's) SFIs is neither legal advice nor statutory guidance, is not intended to be exhaustive, nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the LHB. The law is subject to constant change and the LHB, should seek its own legal advice as appropriate as well as consult with NHS Wales Shared Services Partnership (NWSSP) Procurement Services.

In the event of any conflict between what is contained in legislation and the LHB's SFIs, the former shall prevail.

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement, the service is delivered by NHS Wales Shared Services Partnership (NWSSP) Procurement Services ("**Procurement Services**").

11.1.2 Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the LHB. Where the term 'procurement staff' or 'department' is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of Procurement Services, e.g.; 'Pharmacy' and 'Works', who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised), and the Revised General Consent to enter Individual Contracts [included as Schedule 1 of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP's Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures are:

- kept up to date;
- conform to statutory requirements and regulations;
- adhere to guidance issued by the Welsh Ministers; and
- are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together "**the 2023 Act**") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "**the PSR Wales Regulations**") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("**In-Scope Health Services**") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("**Goods and Non-Health Services**") fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **'In-Scope Health Services Only'** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words **'Goods and Non-Health Services Only'** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.

11.3.3 **'Goods and Non-Health Services Only'** The Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the LHBs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the LHB's SFIs, the former shall prevail.**

11.3.4 **'In Scope Health Services Only'** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the LHB's SFIs, the former shall prevail.**

11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Procurement Policy Framework, including:
    - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)

- The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

11.4.1. The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
- Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 **'In Scope Health Services Only'** The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the LHB doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government's Health Service Procurement: Statutory Guidance; and
- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out:

a) requirements for, and exceptions to, formal competitive tendering (**'Goods and Non-Health Services Only'**);
b) tendering processes including post tender discussions;
c) requirements and exceptions to obtaining quotations (**'Goods and Non-Health Services Only')**;
d) evaluation and scoring methodologies; and
e) approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the LHB delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the LHB to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic and cultural goals in Wales, the LHB must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The seven well-being goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a "sustainable development principle" which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- **Collaboration**: acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- **Integration**: considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies;
- **Involvement**: the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- **Long term**: the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention**: how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The LHB shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The LHB shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, LHBs are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in Welsh Government's 'technical guidance for covered procurement' and the current and subsequent versions of the Wales Procurement Policy Statement (WPPS). The LHB shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The LHB must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and an appropriate representative from the service and other appropriate stakeholders, (depending on the value, risk and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost;
- the likely 'route to market' which will consider the legislative and policy framework set out above;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;
- care for those with the greatest health need first;
- do only what is needed; and
- reduce inappropriate variation.

For **'Goods and Non-Health Services Only'** Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For **'In Scope Health Services Only'** Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the LHB, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the LHB does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the LHB should be submitted by the LHB Board Secretary to the Audit Committee.

11.9.5 The LHB is required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the LHB's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies located outside of Wales.

11.10.2 **'Goods and Non-Health Services Only' -** In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the 2023 Act and the table below. The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

TABLE 'Goods and Non-Health Services Only'

Goods/Services/Works Whole Life Cost Contract value **(figures excl. VAT)**	**Minimum competition** (1)	**Form of Contract**
Below £5,000	Evidence of value for money has been achieved	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
£25,000 plus to the prevailing Procurement Act 2023 threshold (2)	Advertised open call for competition. Minimum of 4 tenders received if available	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required (3)	Formal contract and Purchase Order

(1) Subject to the existence of suitable suppliers
(2) The Procurement Act 2023 - Schedule 1 – threshold amounts
(3) In accordance with the requirements set out in Schedule 1.

11.10.3 **'In Scope Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, the LHB is required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the health service procurement: statutory guidance. The LHB should note that one of the key objectives of the PSR Wales Regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB's SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 **'Goods and Non-Health Services Only'** The LHB must consider the minimum financial thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in Schedule 1 of the 2023 Act.

11.11.2 **'Goods and Non-Health Services Only'** Advice from Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).

11.11.3 **'Goods and Non-Health Services Only'** The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 **'Goods and Non-Health Services Only'** Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000 (excluding VAT), must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.

11.11.5 **'In Scope Health Services Only'** There is no minimum financial threshold for application of the PSR Wales Regulations.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- required timescales are achievable.
- specifications are drafted which:
    - are fit for inclusion in competition documents;
    - are drafted in a manner encouraging innovation by the market;
    - are capable of being responded to and do not narrow competition;
    - deliver in line with legislative and policy frameworks;
    - include robust performance measures to effectively measure and manage supplier performance; and
    - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities. **'Goods and Non-Health Services Only',** under

the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI's) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to 'light touch regime' contracts) and in circumstances where the LHB considers that the supplier's performance under the contract could not appropriately be assessed by reference to key performance indicators (s.52(2) of the 2023 Act)).

11.12.3 **'Goods and Non-Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the "Most Advantageous Tender", which provides contracting authorities with greater flexibility to take into account wider social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life costs, including (where appropriate) the cost of change and / or end of life costs.

11.12.4 **'In-Scope Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:

- Key Criteria (regulation 6);
- Basic Selection Criteria (regulation 22); and
- Exclusions (regulations 25 and 26)

The LHB is required to ensure the appropriate criteria is set with regards the selected procurement process, as set out under the PSR Wales Regulations and Health service procurement: statutory guidance".

11.13 Single Quotation Application (SQA) or Single Tender Application (STA) - 'Goods and Non-Health Services Only'

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- a technical compatibility issue which needs to be met e.g., specific equipment required, or compliance with a warranty cover clause;

- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- when joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/national strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through a Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;
- an acceptable level of assurance is available before presentation for approval in line with the LHB's Scheme of Delegation; and
- an "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the LHB has already entered into an arrangement directly.

11.13.5 As a SQA or STA are only used in exceptional circumstances the LHB, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent repeated inappropriate use of a SQA or a STA by the LHB.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the LHB to attend Audit Committee;
- escalate to the Board;
- request an internal Audit Review;

- request further training; or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. The NWSSP Procurement Manual details the schedule of departures from a SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, Procurement Services will retain a central register of all such activity including SQA/STA's not endorsed by Procurement Services or any exceptional matters.

11.14 Disposals - 'Goods and Non-Health Services Only'

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g., Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the LHB making use of any agreements covering the disposal of such items.

11.14.3 The LHB must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the LHB. Evaluation teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- retaining accurate records;
- monitoring contract performance measures;
- engaging suppliers to ensure performance delivery;
- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by Procurement Services.

11.16.3 Advice on Contract Management best practice is available from Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 **'Goods and Non-Health Services Only'**

11.17.1.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.1.2 If there is no such provision, the 2023 Act defines such limitations. Further information on contract modifications can be found in sections 74-77 of the 2023 Act and in Guidance: Contract Modifications.

11.17.2 **'In-Scope Health Services Only'**

11.17.2.1 Modification of the scope of an existing contract is possible if:

11.17.2.1.1 the modification is clearly and unambiguously provided for in the original contract or framework agreement documents, or

11.11.2.1.2 the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.

11.17.2.2 If provisions set out in 11.17.2.1.1 are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:

- solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
- made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or
- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the LHB budget holder and the LHB Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.5 This ensures an appropriate identification and assessment of potential risks to the LHB's compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.6 The budget holder must seek advice from Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods (**'Goods and Non-Health Services Only'**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract frameworks, such as those managed by Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the Procurement Services to undertake quotation / tendering exercises (**'Goods and Non-Health Services Only'**) on their behalf in line with SFI 11.11 thresholds (**'Goods and Non-Health Services Only'**).

11.18.3 All orders for goods (**'Goods and Non-Health Services Only'**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The LHB will ensure compliance with the 'No Purchase Order, No Pay' policy, the All-Wales policy which was introduced to ensure that Procure to Pay continues to provide high-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;

b) State the LHB's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the LHB by Procurement Services.

SCHEDULE 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as "General Consent to enter individual contracts" replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI's) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

"(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

(a) acquire and dispose of property,

(b) enter into contracts,

(c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case)."

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 ("**the Investment Guidance**") includes the following in relation to Local Health Boards:

"Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031. Organisations should ensure

that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements."

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

"Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above."

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;
- All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;

- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;

ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;

iii) Out of Hours contracts;

iv) All NHS contracts; that is where one health services body contracts with another health service body;

(v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and

(vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).

a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.

b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini-competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales