Audit, Risk and Assurance Committee

Tue 11 March 2025, 10:00 - 13:30

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

Agenda_ARAC_ 11March25final.pdf (3 pages)

1.1. Welcome and Apologies

Attached *Chair*

1.2. Declarations of Interest: Board Members Register of Interests

ARAC_1.2_Board Members Declaration Of Interests summary 2024-25Feb.pdf (4 pages)

10:00 - 10:00
0 min

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.

10:00 - 10:00
0 min

3. ESCALATED ITEMS

There are no items for inclusion within this section

10:00 - 10:00
0 min

4. ITEMS FOR ASSURANCE

4.1. Internal Audit Plan Progress Report

Attached *Head of Internal Audit*

ARAC_4.1_Powys Internal Audit Progress Report March 25 Cover.pdf (2 pages)
ARAC_4.1a_Powys Internal Audit Progress Report March 25.pdf (19 pages)

4.2. Internal Audit Reports: Reasonable Assurance a) Community Cardiology Services, b) Additional Learning Needs Legislation c) Patient Flow & Discharge Management

Attached *Head of Internal Audit*

ARAC_4.2a_Community Cardiology Service Final Internal Audit Report..pdf (13 pages)
ARAC_4.2b_Additional Learning Needs Final Report.pdf (10 pages)
ARAC_4.2c_PTH-2425-06 Patient Flow and Discharge Management Final report.pdf (17 pages)

4.3. External Audit Progress Report

Attached *External Audit*

ARAC_4.3_Audit Wales Update March 2025.pdf (10 pages)

4.4. External Audit Reports: a)Structured Assessment

Deferred

4.5. Audit Recommendations Tracker

Attached *Director of Corporate Governance*

- ARAC_4.5_Audit Recomendations Cover Paper.pdf (8 pages)
- ARAC_4.5a_IA_Recommendations Completed since last report.pdf (3 pages)
- ARAC_4.5b_IA_Recommendations Not Yet Due.pdf (2 pages)
- ARAC_4.5c_IA Recommendations Overdue.pdf (2 pages)
- ARAC_4.5d_IA_Recommendations with Revised Deadlines.pdf (2 pages)
- ARAC_4.5e_EA Recommendations Completed since last report.pdf (1 pages)
- ARAC_4.5f_EA Recommendations Not Yet Due.pdf (1 pages)
- ARAC_4.5g_EA Recommendations Overdue.pdf (1 pages)
- ARAC_4.5h_EA_Recommendations with Revised Deadlines.pdf (1 pages)

4.6. Financial Controls 2024/2025

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

- ARAC_4.6_Financial Controls 2024-25.pdf (8 pages)

4.6.1. COMFORT BREAK (10mins)

4.7. Counter Fraud Update

Attached *Head of Local Counter Fraud*

- ARAC_4.7_Counter Fraud Update Cover Paper.pdf (3 pages)
- ARAC_4.7b_Counter Fraud Report.pdf (4 pages)

4.8. Single Tender Waivers (including extensions to contracts)

Attached *Head of Local Counter Fraud Services*

- ARAC_4.8_Single Tender Waiver Report March 2025.pdf (2 pages)

4.9. Information Governance Performance Report

Attached *Director of Corporate Governance*

- ARAC_4.9_IG Key Performance Report Q3 24-25.pdf (9 pages)

10:00 - 10:00
0 min

5. ITEMS FOR APPROVAL/DECISION/RATIFICATION

5.1. Minutes of the previous meeting held on 14 January 2025

Attached *Chair*

- ARAC_5.1_Draft ARAC Minutes 14Jan25.pdf (9 pages)

5.2. Committee Action Log

Attached *Director of Corporate Governance*

- ARAC_5.2_Action Log 2024-25.pdf (1 pages)

5.3. Internal Audit Annual Plan 2025/26

Attached *Head of Internal Audit*

- ARAC_5.3_Powys THB Internal Audit Plan 2025-26 Cover.pdf (2 pages)
- ARAC_5.3a_Powys THB Internal Audit Plan 2025-26.pdf (26 pages)

5.4. External Audit Annual Plan 2025/26

Attached *External Audit*

ARAC_5.4_PTHB_Audit_Plan_2025_Draft.pdf (24 pages)

5.5. Review of Standing Orders and Standing Financial Instructions

Attached *Director of Corporate Governance*

ARAC_5.5_Annual Review of Standing Orders.pdf (3 pages)

5.6. Audit Handbook

Attached *Director of Corporate Governance*

ARAC_5.6_Audit Process and Reporting Handbook_March 25.pdf (2 pages)
ARAC_5.6a_Audit Process and Reporting Handbook.pdf (18 pages)

5.7. Risk Management Framework

Attached *Director of Corporate Governance*

ARAC_5.7_Risk Management Framework_Cover Paper.pdf (4 pages)
ARAC_5.7a_Appendix A_Risk Management Framework.pdf (24 pages)

5.8. Counter Fraud Work Plan 2025/2026

Attached *Director of Corporate Governance*

ARAC_5.8_Counter Fraud Work Plan 2025-26.pdf (2 pages)
ARAC_5.8a_PTHB_CF_Work Plan 2025-26.pdf (14 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. Approach to the Annual Accounts: (for assurance)

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

ARAC_7.1_Approach to Accounts 24-25 final.pdf (11 pages)

7.2. Declaration of Interests and Register of Gifts and Hospitality (for assurance)

Attached *Director of Corporate Governance*

ARAC_7.2_Cover Report Board Members Delaration of Interests, Gifts & Hospital -Feb2025.pdf (3 pages)
ARAC_7.2a_AppA_Board Members Declaration Of Interests summary 2024-25Feb.pdf (4 pages)
ARAC_7.2b_AppB_Register of Declarations of Gifts & Hospitality 2024-2025.pdf (1 pages)

7.3. Committee Work Programme

Attached *Director of Corporate Governance*

ARAC_7.3_ARAC Work Programme 2024-2025.pdf (1 pages)

7.4. PTHB Glossary (for information)

Attached *Director of Corporate Governance*

ARAC_7.4_Powys Teaching Health Board Glossary January 2025.pdf (5 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/or other Committees

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of the next meeting: 13 May 2025 via Microsoft Teams

AUDIT, RISK AND ASSURANCE COMMITTEE

THURSDAY 11 MARCH 2025
10:00-13:
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	**ESCALATED ITEMS**		
There are no items for inclusion within this section				
	4	**ITEMS FOR ASSURANCE**		
10:05	4.1	Internal Audit Plan Progress Report	Attached	Head of Internal Audit
10:10	4.2	Internal Audit Reports: a) Community Cardiology Service *(Reasonable Assurance)* b) Additional Learning Needs Legislation *(Reasonable Assurance)* c) Patient Flow & Discharge Management *(Reasonable Assurance)*	Attached	Head of Internal Audit
10:40	4.3	External Audit Progress Report	Attached	External Audit
	4.4	~~External Audit Reports:~~ • ~~Structured Assessment 2024~~	Deferred	~~External Audit~~
10:45	4.5	Audit Recommendations Tracker	Attached	Director of Corporate Governance
11:05	4.6	Financial Controls 2024/25	Attached	Deputy Chief Executive / Executive Director of Finance, Capital and Support Services
11:15	**COMFORT BREAK (10mins)**			
11:25	4.7	Counter Fraud Update	Attached	Head of Local Counter Fraud

11:40	4.8	Single Tender Waivers (including extensions to contracts)	Attached	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
11:45	4.9	Information Governance Performance Report	Attached	Director of Corporate Governance
	5	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
11:55	5.1	Minutes of previous meeting held on 14 January 2025	Attached	Chair
	5.2	Committee action log	Attached	Chair
12:05	5.3	Internal Audit Annual Plan 2025/26	Attached	Head of Internal Audit
12:15	5.4	External Audit Annual Plan 2025/26	Attached	External Audit Report
12:25	5.5	Review of Standing Orders and Standing Financial Instructions	Attached	Director of Corporate Governance
12:35	5.6	Audit Handbook	Attached	Director of Corporate Governance
12:40	5.7	Risk Management Framework	Attached	Director of Corporate Governance
12:50	5.8	Counter Fraud Work Plan 2025/2026	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section.				
	7	**CONSENT AGENDA**		
	7.1	Approach to the Annual Accounts **Purpose:** For Assurance	Attached	Director of Corporate Governance & Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
	7.2	Declaration of Interests and Register of Gifts and Hospitality **Purpose:** For Assurance	Attached	Director of Corporate Governance
	7.3	Committee Work Programme **Purpose:** For Information	Attached	Director of Corporate Governance
	7.4	PTHB Glossary **Purpose:** For Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
13:00	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: 13 May 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 2024/25

Updated: February 2025

Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/02/2025	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	Feb-25	Current	Director of Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment		

		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	08/07/2024	
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owneer:Property in the County of Powys	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		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		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL		

and Support Services		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2024	
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance / Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic	**Lucie Cornish**								

Improvement and Transformation		Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Apr-24	Current	Independent Member – ateb - housing Association	£2,960 Per Annum	29/01/2025	
				Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary		
		Spouse/Partner or other Relative	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil		
				Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board	Nil		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 4.1

Audit, Risk and Assurance Committee	**11 March 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** the proposed adjustment to the 2024/25 plan.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

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

The following audit reports have been finalised since the January 25 meeting of the Committee:

- Community Cardiology Service (Reasonable Assurance)
- Additional Learning Needs Legislation (Reasonable Assurance)
- Patient Flow and Discharge Management (Reasonable Assurance)

The Executive summaries for each of the final reports are included within the progress report, and the full copies of the reports are also included as separate items within the agenda.

The progress report also includes details of a two proposed adjustments to the 2024/25 plan.

BACKGROUND AND ASSESSMENT:

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

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

The 2024/25 plan was formally approved by the Audit, Risk and Assurance Committee at its March 24 meeting.

The progress report provides the committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee, and details of a proposed adjustment to the plan.

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

NEXT STEPS:

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

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
March 2025

NWSSP Audit and Assurance Services

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

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

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2024/25 Internal Audit plan.

The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

The plan for 2024/25 was agreed by the Audit, Risk & Assurance Committee in March 2024 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Outcomes from Completed Audit Reviews

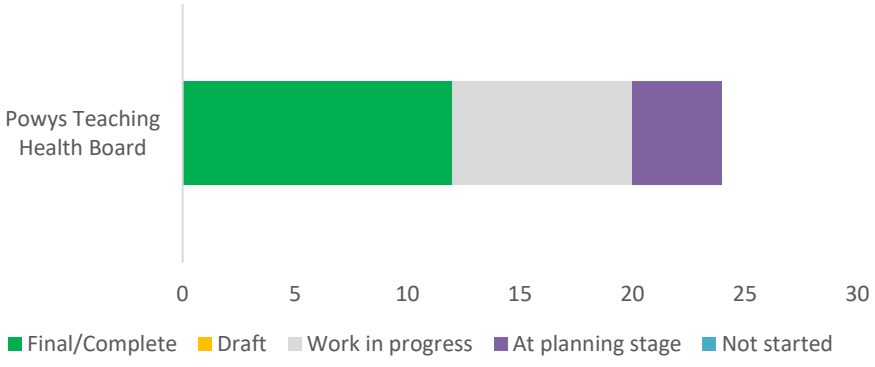
Three assignments from the 2024/25 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Community Cardiology Service	Reasonable	
Additional Learning Needs Legislation		
Patient Flow & Discharge Management		

3. Delivery of the 2024/25 Internal Audit Plan

There are a total of 24 reviews included within the 2024/25 Internal Audit Plan (Including the change highlighted in section 4), and overall progress to date is summarised below.



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

In addition, there are eight audits that are currently work in progress with a further four at the planning stage.

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

Appendix A also includes details of the audit from the 2023/24 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2023/24. The outcome from that audit will feed into the 2024/25 Opinion.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators (KPI).

4. Changes to the 2024/25 Plan

The audit of Site Co-ordination has been proposed for deferral to the 2025/26 plan due to the recent change in director responsibility for this area and on-going recruitment to the Head of Facilities post. The deferment has been agreed by the Executive Director of Finance, Capitol & Support Services.

The planned detailed follow-up of the previous Limited Assurance Estates Condition audit has been proposed for removal from the 2024/25 plan, due to the funding constraints in addressing the underlying issues. Assurance on progress with implementation of the agreed actions will be provided through the year-end action tracking work. The removal has been agreed by the Executive Director of Finance, Capitol & Support Services.

5. Final Report Summaries

5.1 Community Cardiology Service

Purpose

A review of the structure and delivery of the Community Cardiology Service implemented in North Powys, to inform further roll-out across Powys.

Overview

The Health Board's Community Cardiology Service (the 'Service') provides a direct access, one-stop, cardiology diagnostic and management service with a comprehensive cardiac rehabilitation programme.

The development of the service was taken forward through the Circulatory Renewal Programme following a successful application for non-recurrent funding to the Wales Cardiac Network to pilot the first phase of implementation in North Powys during 2022-23. The service continues to operate in North Powys, with a proposal in place for expansion into Mid Powys, ahead of the creation of a pan Powys service.

The Service in the North is provided by a multi-disciplinary team consisting of a broad range of specialist staff. The team includes GP(s) with Special Interest (GPwSI), Specialist Cardiac Nurses and physiotherapist, Specialist Cardiac Physiologist, Cardiac Rehabilitation Specialist, Assistant Practitioner, administrative support (patient services, radiology & specialist nurse teams) and the wider multidisciplinary team. The Service consists of three elements:

- A Cardiology Diagnostics and Management clinic for suspected heart failure, cardiac chest pain or rhythm disturbance;
- Cardiac Rehabilitation for those with confirmed significant heart disease; and
- Supporting the Local Enhanced Service for GP arrhythmia management.

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

- The absence of a formal documented Community Cardiology Service structure setting out its relationship to, and reporting lines within the Health Board;
- The governance arrangements in place during the Service's implementation phase have not evolved to support the management and oversight of the Service now that it is fully operational;
- The absence of formal risk management processes, in accordance with Health Board Risk Management requirements;
- Ensuring that the timescales relating to patient's contact and subsequent assessment are in compliance with the Service's Standard Operating Procedure criteria, and also that appointment notifications to patients are recorded on the patient electronic databases;
- Enhancements to the Cardiac Rehabilitation discharge/onward referral pathway through recording of GP/clinician notification and issue of clinical outcome reports on patient databases; and
- The absence of clear reporting and escalation lines for Service Performance Management to Health Board Committee level.

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

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for information:

- The update of the Community Cardiology Standard Operating Procedure should be submitted to the Community Services Manager for review, and then formal approval should be obtained by the CSG Operational Group.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	1,2,3	**Limited**
2	There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	-	**Substantial**
3	Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant NICE and BACPR guidelines.	4	**Reasonable**
4	Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	5	**Reasonable**
5	Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	-	**Substantial**
6	Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	6	**Reasonable**

Management Actions

2 High Priority

4 Medium Priority

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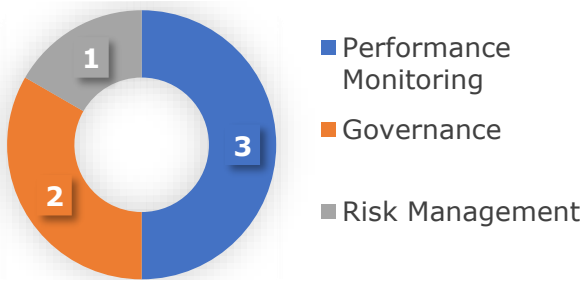
Themes



Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

5.2 Additional Learning Needs Legislation

Purpose

Our review of the Additional Learning Needs Legislation was completed in line with the 2024/25 Internal Audit Plan for the Powys Teaching Health Board (PTHB, the 'Health Board').

The additional learning needs (ALN) system supports children and young people aged 0 to 25 in Wales with ALN and replaces the special educational learning needs (SEN) system. The ALN system is being implemented over a four-year period, which concludes in August 2025.

The ALN legislative framework was created by the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALNET Act, ALN Act), the Additional Learning Needs Code for Wales 2021 (the ALN Code) and regulations made under the Act.

The Act became lawful from 2021, but implementation is being phased in over a four-year period. In accordance with Section 61 of the Act, Local Health Boards must have a Designated Education Clinical Lead Officer (DECLO) for co-ordinating the Board's functions in relation to children and young people with ALN. Chapter 9 of the ALN Code details their specific roles and responsibilities. The Act also continues the existence of the Special Educational Needs Tribunal for Wales, which hears and decides appeals and applications in relation to children and young people who have or may have ALN but renames it the Education Tribunal for Wales.

Overview

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

- Collaborative Governance arrangements for the partnership are insufficiently robust.
- Whilst training exercises have taken place, currently there is no formal training programme in relation to ALN operating within PTHB.
- The partnership's Work Plan has not been subject to adequate monitoring or scrutiny.
- Data validation processes are ongoing with respect to the case management system and therefore assurances cannot yet be placed on the accuracy of data contained within it.

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

- The Terms of Reference belonging to the ALN Integrated Steering Group (AISG) lists attendees from all partner organisations. Agendas and action logs are produced but records of attendees have not been maintained.
- A multi-agency Strategic Plan has been produced by Powys County Council (PCC) on behalf of the partnership, but there is no evidence that PTHB was involved in the process. Efforts should be made to ensure that the Health Board is able to demonstrate its input to the ALN and Inclusion Strategic Plan where possible.
- Outcome monitoring procedures are yet to be developed. The establishment of effective outcome monitoring procedures should be raised with the ALN Integrated Steering Group.
- Performance monitoring procedures are yet to be developed. Performance monitoring procedures should be defined in consultation with the Women and Children's Quality and Performance Group.

- A Standard Operating Procedure has been produced in respect of the Health Board's Duties in relation to the ALN Tribunals process; the document has been submitted to the AISG for approval / ratification but has not yet been approved..

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	Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	1	**Reasonable**
2	There is sufficient training and engagement with staff.	2	**Limited**
3	Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	3	**Limited**
4	There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	4, 5	**Reasonable**
5	There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	4	**Reasonable**
6	There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal.		**Substantial**
7	Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met.		**Substantial**

Management Actions

2 High Priority

3 Medium Priority

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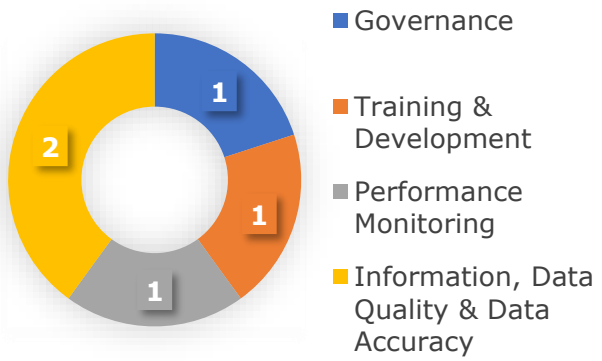
Themes



Risk Types

Legal & Regulatory Non-Compliance

5.3 Patient Flow & Discharge Management

Purpose

The overall objective of the audit was to review the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team.

Overview

Providing safe, timely and effective discharge for every person who attends hospital is essential, however due to the ageing demographic and an increasing number of older patients being admitted, the complexity of the discharge planning has increased.

The Welsh Governments (WG) 'Hospital Discharge Guidance' issued in September 2024 sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. The principles and processes that support effective discharge are set out in the Discharge to Recover then Assess (D2RA) Pathways Guidance. All patients with a decision to admit to hospital should be assessed and provisionally allocated to one of four pathways.

The national 'Six Goals for Urgent and Emergency Care Programme' sets out the expectations for the Health Boards and their partners for the delivery of the right care, in the right place, first time for physical and mental health. It outlines six goals to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care. The goals include:

Goal 5 – Optimal hospital care and discharge practice from the point of admission. Goal 6 – Home first approach and reduce the risk of readmission.

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

- The Community Hospital Discharge policy is outdated and requires revision to align with the Welsh Government's 'Hospital Discharge Guidance' released in September 2024.
- Staff members are required to retake the D2RA training course to guarantee full compliance and to ensure that their records are updated in the ESR system.
- Staff members comprehension of Red2Green (R2G) days did not completely align with the guidance provided by Welsh Government. Additionally, the recording of R2G days within the DigiFLO whiteboards indicated that the wards included in the sample were not effectively updating or utilising the R2G feature.
- We were unable to locate adequate evidence within the current systems to explain the rationale behind the decision regarding the D2RA Pathway.
- A Clinical frailty Score for patients over 65 does not form part of the patient assessment on admission to the Community Hospitals.
- The remaining six key findings are operational in nature and include the utilisation of DigiFLO whiteboards, use of Inpatient Notes within WNCR, and delays in setting an estimated date of discharge.

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

- Pharmacy are not always in attendance at MDT meetings.
- User Access Guidance for the Patient Flow List has been prepared and is currently under review by the Local Authority for approval. Once finalised, it needs to be included as an Appendix to the Integrated Patient Flow SOP.
- A comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial.
- Identifying the attendees of meetings proved challenging due to the absence of this being documented.
- There were limited instances of delays in the identification of a Powys Plan pathway for patients in the Wye Valley Trust.

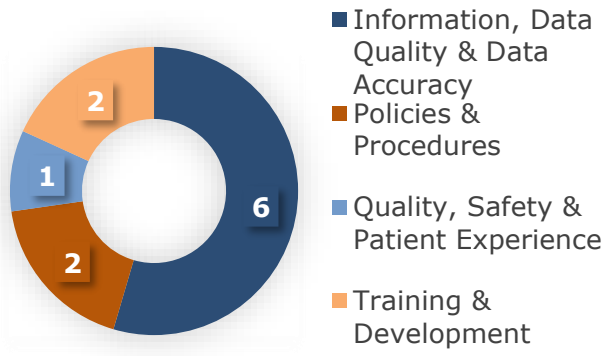
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	1,2	**Reasonable**
2	Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	3	**Reasonable**
3	Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	4,5,6,7,8,9,10,11	**Limited**
4	The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	10,11	**Reasonable**
5	Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.		**Substantial**
6	Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.		**Substantial**

Management Actions

2	9
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2023/24 Plan								
Integrated Performance Framework	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.		Planning, Performance and Commissioning			Final Report	Substantial	October
2024/25 Plan								
Integrated Plan Development Process	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	13	Planning, Performance and Commissioning	1		Final Report	Reasonable	October
Cleaning Standards	Review of processes and controls in place to ensure compliance with national cleaning standards.	21	Finance, Capital and Support Services	1		Final Report	Reasonable	October
Core Financial Systems – Treasury Management	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	15	Finance, Capital and Support Services	2		Final Report	Substantial	January
Staff Retention	Review and assessment of the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.	11	People and Culture	2/3		Final Report	Reasonable	January
Capital Systems	A review of the arrangements in place for the selection and award of advisers and contractors at health board projects; to include the use of local, regional, and national framework arrangements, adequacy of contractual arrangements applied etc.	26	Finance, Capital and Support Services	2		Final Report	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Energy Management	Determine the adequacy of and operational compliance with, the established systems for the management and control of energy consumption within the Health Board, will also take account of other supporting regulatory and procedural requirements.	25	Finance, Capital and Support Services	2		Final Report	Reasonable	January
Board & Committee Structure / Effectiveness	Evaluate the Health Board's Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	2	Corporate Governance / Board Secretary	2		Final Report	Substantial	January
Deprivation of Liberties Safeguards (DoLS)	Review of the arrangements for ensuring compliance with DoLS requirements including role of Best Interest Assessors. Will need to consider potential scope of this audit further.	10	Nursing, Quality, Women and Family Health	3		Final Report	Limited	January
Records Management	Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.	18	Corporate Governance / Board Secretary	3		Final Report	Substantial	January
Community Cardiology	Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.	24	Primary, Community Care and Mental Health	3		Final Report	Reasonable	March
Additional Learning Needs Legislation	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	19	Nursing, Quality, Women and Family Health	2/3		Final Report	Reasonable	March
Patient Flow and Discharge Management	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.	6	Primary, Community Care and Mental Health	1		Final Report	Reasonable	March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Contract Management	To provide assurance that the Health Board has appropriate contract management arrangements in place. Review of Health Board arrangements along with the interaction and assurance received from NWSSP Procurement Services.	14	Finance, Capital and Support Services	3		Work in Progress		May
Primary Care – GMS Unified Contract	Review of the processes for managing the GMS Unified contract performance framework and monitoring and reporting performance.	16	Primary, Community Care and Mental Health	3		Work in Progress		May
Follow-up: Information Governance	Follow-up of 23/24 Limited Assurance report.	17	Corporate Governance / Board Secretary	3		Work in Progress		May
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Following on from the 23/24 audit of the corporate level arrangements.	23	Public Health / Primary, Community Care and Mental Health	3		Work in Progress		May
Cancer Services	A review of Cancer Services included for the second half of the plan. Scope could cover the Cancer Tracking Service or Harm Review Process, to be confirmed later in the year.	5	Medical	3/4		Planning – Draft brief issued		May
Medicines Management – Pharmacy Stores	Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing.	4	Medical	4		Work in Progress		May
Capital Project – Llandrindod Wells Phase 2	To assess the THB's processes, procedures and operational management of the delivery of the Llandrindod Wells redevelopment programme.	27	Finance, Capital and Support Services	4		Work in Progress		May
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance / Board Secretary	4		Work in Progress		May
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and	7	Primary, Community	~~2/3~~	4	Planning		May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
	treatment plans within the Mental Health Service and plans in place to improve these.		Care and Mental Health					
Quality & Safety Governance (Duty of Quality)	Review of the implementation and operation of the new arrangements around quality and governance structures and floor to Board reporting. Potentially include a review of the Integrated Quality Report.	9	Nursing, Quality, Women and Family Health	4		Work in Progress		May
Partnership Governance Framework	Review of the development and implementation of the Framework.	12	Planning, Performance and Commissioning / Corporate Governance	4		Planning		May
Medical Devices - Mattresses	Review of actions taken to address previous incidents that have occurred within the Health Board around mattresses. Provide assurance on whether revised processes and controls are being applied.	20	Allied Health Professions, Health Sciences & Digital	4		Planning		May
Reviews removed from the plan								
Policy Management	Review the arrangements and processes in place for the creation, management and review of Health Board policies.	3	Corporate Governance / Board Secretary	The Director of Corporate Governance / Board Secretary identified that a new system for management of policies had been approved for implementation during 2024/25, so the audit was deferred to 2025/26 to provide assurance on the new system. Approved by July 24 ARAC.				
Local Primary Mental Health Support Services	Review of how the Local Primary Mental Health Support Services are structured, managed and delivered.	8	Primary, Community Care and Mental Health	Removed from the 24/25 plan due to significant delay in agreeing the scope of the audit which meant resource was no longer available to deliver. Approved by January 25 ARAC.				
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	22	Finance, Capital and Support Services	Deferred to the 2025/26 plan due to the recent change in director responsibility for this area and on-going recruitment to the Head of Facilities post. To be approved by March 25 ARAC				
Estates Condition Follow-up	Follow-up of 23/24 Limited Assurance report.	28	Finance, Capital and Support Services	Proposed for removal from the 25/26 plan, due to the funding constraints in addressing the underlying issues. To be approved by March 25 ARAC				

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Integrated Performance Framework	Substantial	Final	29/07/24	19/08/24	15/08/24	15/08/24	G
Integrated Plan Development Process	Reasonable	Final	22/08/24	13/09/24	30/09/24	30/09/24	R
Cleaning Standards	Reasonable	Final	20/09/24	11/10/24	27/09/24	30/09/24	G
Core Financial Systems – Treasury Management	Substantial	Final	25/10/24	15/11/24	15/11/24	19/11/24	G
Staff Retention	Reasonable	Final	28/10/24	18/11/24	07/11/24	08/11/24	G
Board & Committee Structure/Effectiveness	Substantial	Final	28/11/24	19/12/24	03/12/24	03/12/24	G
Capital Systems	Reasonable	Final	14/10/24	04/11/24	19/11/24	21/11/24	R
Energy Management	Reasonable	Final	29/10/24	19/11/24	05/12/24	05/12/24	R
Deprivation of Liberties Safeguards	Limited	Final	10/12/24	03/01/25	23/12/24	30/12/24	G
Records Management	Substantial	Final	12/12/24	07/01/25	06/01/25	06/01/25	G
Community Cardiology	Reasonable	Final	05/02/25	26/02/25	18/02/25	18/02/25	G
Additional Learning Needs Legislation	Reasonable	Final	19/02/25	12/03/25	27/02/25	27/02/25	G
Patient Flow and Discharge Management	Reasonable	Final	06/02/25	27/02/25	27/02/25	27/02/25	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	May 2024	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	R	53% 8 from 15	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	92% 12 from 13	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	77% 10 from 13	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 13 from 13	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

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Community Cardiology Service

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2425-24
Fieldwork	December 2024 – February 2025
Executive Sign Off	18th February 2025
Audit Committee	March 2025
Executive Lead	Elaine Lorton, Executive Director of Primary, Community Services & Mental Health
Audit Team	Ian Virgill, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit Stuart Bodman, Principal Internal Auditor

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

Executive Summary

Purpose

A review of the structure and delivery of the Community Cardiology Service implemented in North Powys, to inform further roll-out across Powys.

Overview

The Health Board's Community Cardiology Service (the 'Service') provides a direct access, one-stop, cardiology diagnostic and management service with a comprehensive cardiac rehabilitation programme.

The development of the service was taken forward through the Circulatory Renewal Programme following a successful application for non-recurrent funding to the Wales Cardiac Network to pilot the first phase of implementation in North Powys during 2022-23. The service continues to operate in North Powys, with a proposal in place for expansion into Mid Powys, ahead of the planned creation of a pan Powys service.

The Service in the North is provided by a multi-disciplinary team consisting of a broad range of specialist staff. The team includes GP(s) with Special Interest (GPwSI), Specialist Cardiac Nurses and physiotherapist, Specialist Cardiac Physiologist, Cardiac Rehabilitation Specialist, Assistant Practitioner, administrative support (patient services, radiology & specialist nurse teams) and the wider multidisciplinary team.
The Service consists of three elements:

- A Cardiology Diagnostics and Management clinic for suspected heart failure, cardiac chest pain or rhythm disturbance;
- Cardiac Rehabilitation for those with confirmed significant heart disease; and
- Supporting the Local Enhanced Service for GP arrhythmia management.

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

- The absence of a formal documented Community Cardiology Service structure setting out its relationship to, and reporting lines within the Health Board;
- The governance arrangements in place during the Service's implementation phase have not evolved to support the management and oversight of the Service now that it is fully operational;
- The absence of formal risk management processes, in accordance with Health Board Risk Management requirements;
- Ensuring that the timescales relating to patient's contact and subsequent assessment are in compliance with the Service's Standard Operating Procedure criteria, and also that appointment notifications to patients are recorded on the patient electronic databases;
- Enhancements to the Cardiac Rehabilitation discharge/onward referral pathway through recording of GP/clinician notification and issue of clinical outcome reports on patient databases; and
- The absence of clear reporting and escalation lines for Service Performance Management to Health Board Committee level.

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

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The update of the Community Cardiology Standard Operating Procedure should be submitted to the Community Services Manager for review, and then formal approval should be obtained by the CSG Operational Group.

Scope & Assurance Summary

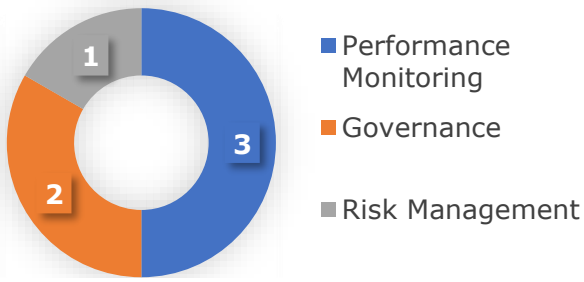
	Objectives	Related Findings	Assurance
1	The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	1,2,3	**Limited**
2	There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	-	**Substantial**
3	Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant NICE and BACPR guidelines.	4	**Reasonable**
4	Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	5	**Reasonable**
5	Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	-	**Substantial**
6	Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	6	**Reasonable**

Management Actions

2 High Priority

4 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	**Limited**

Overview / Summary of Observations

The Community Cardiology Service has no formal documented structure that outlines its position within the overall Health Board organisational structure.

The Service is also not currently supported by effective local governance and management arrangements that facilitate its operational decision making and reporting mechanisms. We note that local governance arrangements were in place during the Services' project management and pilot phases, but these have not been continued or developed to support the Service now that it is fully operational.

The Service has Standard Operating Procedures in place that describe the purpose and current operational processes of its three constituent Service areas and also the roles of the key staff within these service areas. We note that at the time of our audit these had been reviewed and updated but required formal approval.

Service management has identified that the current budgeted staffing levels in respect of the Cardiology Diagnostics & Management Clinic and Cardiac Rehabilitation Service are inadequate to ensure efficient and effective delivery of patient management and treatment. This position is evidenced by the times for referrals and assessments we noted as part of our testing under Objective 3. A Business Case to increase and improve staffing is due to be submitted to the Health Board Investments Benefits Group in early 2025.

The operational Service also lacks formal risk management arrangements as required and stipulated by the Health Board's Risk Management Framework. Again, we note that risk management was in place through the Services' project phase.

	Key Findings	Risk & Impact	Agreed Management Action
1	<u>Community Cardiology Service Structure</u> At the time of our audit, there is no formally documented structure for the Community Cardiology Service and its three constituent service areas, (Cardiology Diagnostics & Management Clinic, Cardiac Rehabilitation Service, and Local Enhanced Service for GP Arrythmia Management) and also its relationship to the reporting structure and lines of accountability within the overall Health Board organisational framework. The Community Cardiology Service staffing structure is not formally outlined within its Standard Operating Procedure. We note that the 22.5 hours/week and 15 hours/week currently budgeted to and respectively worked by the Cardiac Rehabilitation Specialists in both North & Mid Powys and South Powys may not be sufficient given current and potential future levels of patient demand and activity.	The Service fails to deliver its stated objectives.	**Agreed Action:** Business Case to be taken to IBG in February 2025, to ensure sustainable and robust service structure and delivery. Standard Operating Procedure (SOP) is currenting being updated to reflected current service and vision for future. When draft completed, SOP to be formally signed off in March 2025.

	Additionally, the Cardiology Diagnostics & Management Clinic is substantively operated by a part time (0.5 WTE) GP with a Specialist Interest in Cardiology, and a Cardiac Physiologist. In the event of staff absences or annual leave, there is no cover and clinics/services do not proceed. As such, there are resultant increased waiting times due to current limited staff resources available, and also insufficient numbers of patient assessment locations (e.g. leisure centres, community centres) in which Cardiac Rehabilitation programme sessions are undertaken. We acknowledge that these issues are known to senior management, and a Business Case has been drafted, and is to be submitted to the Health Board Investments Benefits Group (IBG) in early 2025 to request additional funding to help mitigate the staffing issues within the Service. However, in the event that the Business Case is not successful, it is unclear whether further option appraisals or senior management consideration has been undertaken to source the additional funding required, and also that for any further Service expansion.		**Expected Evidence of Implementation:** Copy of Business case and minutes of IBG meeting. Copy of updated SOP and evidence of sign-off.
	Theme: Governance	**High Priority** Control Design	**Officer: Helen Hathaway, Cardiology Service Lead / Donna Jones, Community Service Manager** **Date: March 2025**
2	<u>Governance and Management Oversight</u> Currently the governance and management oversight arrangements in place for the Community Cardiology Service are outdated and reflect the nature of the Service during its project management and pilot phases, and not that of its fully operational status. The Terms of Reference (ToR) for the 'Community Cardiology Services Implementation Group' that is in place require updating and reconstitution to reflect the fully operational Service objectives and delivery across the Service. This ToR does not accurately reflect current Service objectives, CSG operational management and decision-making arrangements and also Directorate/organisational reporting lines. Furthermore, the 'Community Cardiology Services Implementation Group' has not met since June 2024, and this	The Service fails to deliver its stated objective.	**Agreed Action:** Service Governance Community Cardiology Meeting now re-started, with an updated ToR and Agenda, to meet bi-monthly and chaired by Community Service Manager, first meeting 12th of February 2025. **Expected Evidence of Implementation:** Papers for Service Governance Meeting. Copy of updated TOR.

	current absence of a formal management oversight and decision-making group poses a risk to sound and effective governance within the Community Cardiology Service.	**High Priority**	**Officer: Helen Hathaway / Donna Jones** **Date: Complete**
	Theme: Governance	Control Operation	
3	<u>Risk Management Processes</u> No formal risk management oversight, risk identification and recording, and risk review processes are in place within the Community Cardiology Service, in accordance with the Health's Board Risk Management Framework requirements. We do, however, acknowledge there is regular reporting and escalation of key Service risks to the respective CSG Operations and Quality & Safety meetings, but these are narrative based only and are not scored to reflect their likelihood and impact, and are not supported by risk mitigation actions. Additionally, we could not establish if key risks are being escalated to inform the Community Service Group risk register. We note that an appropriately constituted and scored risk register was in place for the Community Cardiology Service during its project management phases, but this was dated 2022 and was not revised and updated to reflect the transition into a fully operational Service and has not been maintained on an ongoing basis to the present time.	The Service fails to deliver its stated objectives.	**Agreed Action:** Risk Register now in place from January 2025 and being reviewed and escalated as indicated by the scoring system of risk matrix.
			Expected Evidence of Implementation: Copy of Risk Register.
		Medium Priority	**Officer: Helen Hathaway, Cardiology Service Lead / Donna Jones, Community Service Manager**
	Theme: Risk Management	Control Design	**Date: Complete**

Objective 2: There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	**Substantial**

Overview / Summary of Observations

The Community Cardiology Service has a current Standard Operating Procedure (SOP) that formally documents patient referral pathways for each of the three Service areas and outlines the stages of patient flow and management prior to and including assessment/treatment and through to discharge or onward referral, and also that of the interconnectivity between the Service areas.

We were informed that Service staff and referring Mid and North Powys GPs/ Health Board clinicians have been provided with copies of the SOP and are aware of its stated referral and patient management criteria via training sessions.

However, the SOP has recently been subject to revision and update and requires formal review and approval by Clinical Service Group management.

Objective 3: Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant clinical guidelines.	**Reasonable**

Overview / Summary of Observations

Referral and assessment stages of the patient pathways are outlined in the Community Cardiology Standard Operating Procedure (SOP).

Our review and testing of a sample of patients that were referred into, and assessed by, the Cardiology Diagnostics & Management Clinic and North & Mid Powys Cardiac Rehabilitation Service respectively between April and October 2024, confirmed that they were managed in line with the pathway stages stated within the SOP, and in accordance with relevant NICE and BACPR guidelines which are cited therein.

However, our testing identified that lengthy referral to assessment and then treatment timescales are currently incurred within the North & Mid Powys Cardiac Rehabilitation Service.

Our review of key patient pathway dates for each sampled patient recorded on the Cardiac Rehabilitation Waiting Database List, confirmed that they reconciled to those held on the WPAS (Welsh Patient Administration) and WCCIS (Welsh Community Care Information System) systems.

No testing was undertaken in respect of an assessment and treatment pathway relating to the Local Enhanced Service (LES) for GP Arrythmia Management, as this Service relates to a GP Practice commissioning process relating to the provision and use of cardiac rhythm monitoring devices (Kardia Mobile/Zio) that supports clinical assessment and treatment within the other two services.

We also note that not all parts of the patient pathway as stated in the SOP were reviewed during our testing as they relate to medical/clinical decision making processes.

	Key Findings	Risk & Impact	Agreed Management Action
4	<u>Patient Referral and Assessment Pathway Management</u> • <u>Cardiology Diagnostics & Management Clinic</u> Testing of a sample of patients identified that referrals from GPs/referring clinicians into the Cardiology Diagnostics & Management Clinic are managed quite efficiently, whereby it took an average of 11 working days. 64% of the total sample were received by the Clinic on the same day that the referral was made. The timescale from which the referrals were received by the Clinic to the date a first Clinic appointment is booked was an average of 34 working days, and an average of 58 working days for those patients who could not attend the first appointment offered but then attended a second offered appointment. Whilst the average timescale was above the 6-week target stated in the SOP, we acknowledge that this is due to the issues around the current staffing establishment, as stated previously in this Report. • <u>North & Mid Powys Cardiac Rehabilitation Service</u> Current lengthy timescales were also identified through our sample-based testing and review of the Cardiac Rehabilitation patient referral and assessment pathway, these being; ➢ Average total timescale from Cardiac Diagnostics Clinic/Cardiac Nursing Service onward internal referral to patient receiving assessment into their Cardiac Rehabilitation Sessions - 49 working days ➢ Average total timescale from referral receipt by the Cardiac Rehabilitation Service to commencement of treatment Sessions - 56 working days We acknowledge that these limiting factors are also known to senior management and are covered by the Business Case, as previously stated in this Report. Our testing also identified issues around ensuring compliance with the SOP criteria in respect of Cardiac Rehabilitation patients not being contacted by the Service within 3 working days after receipt of their referral, and an assessment not taking place within 10 working days of the receipt of their clinician's referral.	Potential patient harm due to delays in receiving services and / or non-compliance with relevant clinical guidelines.	**Proposed Agreed Action:** Updated SOP to reflected KPIs and National Guidelines for Cardiac Rehabilitation waiting times. Updated patient pathway, referrals to be triaged electronically via WAP or WCCIS in the near future, and all patient activity to be recorded electronically in WCCIS or WPAS, aiming end of March for new electronic pathway to be completed. **Expected Evidence of Implementation:** Copy of updated SOP. Relevant dates recorded in WPAS and WCCIS.

	Furthermore, dates relating to the issue of appointment invitation letters/calls for patients to attend Cardiac Rehabilitation assessment sessions are not consistently recorded on WPAS and WCCIS.	**Medium Priority**	**Officer: Helen Hathaway, Cardiology Service Lead** **Date: April 2025**
	Theme: Performance Monitoring	Control Operation	

Objective 4: Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	**Reasonable**

Overview / Summary of Observations

Efficient pathway management, supported by clearly outlined processes are in place for patient discharge from the Community Cardiology Service, and / or onward referral to further clinical services if required.

These, however, could be strengthened through recording on WPAS and WCCIS of the dates when a GP/referring clinician is informed of the patients discharge from the Service and provided with a clinical outcome report of the Cardiac Rehabilitation Programme undertaken.

We note that not all parts of the discharge pathway as stated in the SOP can be reviewed and tested as they relate to medical/clinical decision making processes undertaken during this stage of the pathway.

	Key Findings	Risk & Impact	Agreed Management Action
5	<u>Discharge and Onward Referral Pathway Management</u> Based upon the patients we sampled, the timescale between the Cardiology Diagnostics & Management Clinic discharge date to that of the GP/Referrer being notified and issued a Clinic assessment outcome report is 4 working days. In respect of the Cardiac Rehabilitation Service, we did not assess the timescale from assessment date to discharge/onward referral date, as this is a standard 8 weeks of cardiac rehabilitation, fitness monitoring sessions and provision of clinical advice, and we acknowledge that this may also be extended if deemed clinically appropriate to the need of the patient undergoing the sessions. Our key finding relates to there being no entries recorded on WPAS and WCCIS in respect of when a GP/referring clinician is informed of the patients discharge from the Service and the clinical outcome report of the Cardiac Rehabilitation Programme is issued to them. We are therefore unable to provide any assurance around the timeliness of this element of the pathway.	Potential patient harm due to delays in receiving services and / or non-compliance with relevant clinical guidelines.	**Proposed Agreed Action:** Discharge letters now being sent out to GP practices for all patients completing cardiac rehab and/or discharged from the service. Dates will be added to patient WPAS and WCCIS files. **Expected Evidence of Implementation:** Relevant dates recorded in WPAS and WCCIS.
	Theme: Performance Monitoring	Control Operation	**Medium Priority** **Officer: Helen Hathaway, Cardiology Service Lead** **Date: Complete**

Objective 5: Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	**Substantial**

Overview / Summary of Observations

The Community Cardiology Service is supported by several robust clinical and administrative patient management systems that allow for effective integrative recording and reporting of patient referrals, treatment activity, onward referral and discharge.

Cardiac Diagnostics Clinic

Referrals via GPs or any internal referrals are made in writing via letter or GP electronic referral, and the supporting clinical information recorded via two clinical systems, RADIS2 and PACS (Picture Archiving and Communications System).

RADIS2 performs functions such as patient scheduling and clinical reporting involving medical images such as x-rays, CT and MRI scans and ultrasound and works in conjunction with the (PACS) to manage the storage, retrieval, distribution and presentation of images and allows the sharing of these images nationally.

The conjoining of information from these systems then feeds into WPAS (Welsh Patient Administration) which is used to plan clinic appointments, treatment plans and then refer into another function of the Service, or discharge back to the GP for local review and clinical management.

Cardiac Rehabilitation

Data for referral, treatment and discharge/onward referral is sourced from WPAS and the Cardiac Rehabilitation patient caseload/treatment information from the WCCIS (Welsh Community Care Information System).

WCCIS is an integrated system that provides sharing of information between community health and social care, and access to relevant information on the care provided to a range of health and social care professionals, to show where a patient is with their treatment.

The content of these systems is informed by information provided by the GP electronic referral system, and also that of administration staff who support the Service via letters written from/to GPs during referral and discharge stages.

Additionally, within both the North & Mid and South Cardiac Rehabilitation service areas, patient referral, treatment, waiting list and discharge activity is also recorded on an operational day-to-day 'at a glance' basis by the Cardiac Rehabilitation Specialists on an Excel Waiting List Database.

Our testing undertaken in Objectives 3 and 4 of this Report evidences the flow and use of the data from these systems into and through the patient pathways and also confirms that key dates held on WPAS and WCCIS databases fully reconcile.

Objective 6: Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	**Reasonable**

Overview / Summary of Observations

The Community Cardiology Service is supported by a Power BI database that integrates the patient data held on the clinical and patient management systems and produces management information relating to Service performance that is regularly reported to the Clinical Service Group Operations and Quality & Safety Groups.

However, we were unable to verify if there is any provision in place for onward reporting of the Service's performance to an appropriate Health Board Group or Committee.

The Service has Key Performance Indicators (KPIs) in place that outline patient activity and Service performance measures to aid monitoring of service delivery.

Key Findings	Risk & Impact	Agreed Management Action
<u>Reporting and Escalation of Service Performance Management</u> Information used for reporting patient activity and Service performance information comes from the IFOR (Information Focused Online Reporting) Power BI database that electronically sources data from WCCIS and WPAS, and information on WPAS is informed from the clinical systems PACS and RADIS. We note that patient referral, caseload and waiting list activity relating to the Community Cardiology Service is being reported to the Clinical Service Group Operations and Quality & Safety meetings on a bi-monthly basis. However, given the current absence of a formalised Service structure and reporting arrangements, it is unclear whether this information is being reported onward/escalated to any Health Board Group/Committee meetings.	Areas of poor performance are not identified or addressed.	**Agreed Action** Demand and capacity data is being closely monitored for each area and specialism for community cardiology. Discussed during bimonthly service governance meeting and escalated as needed. To set up a demand and capacity graph for each service area, to show monthly data and trend of demand, to be completed by end of March 2025. **Expected Evidence of Implementation:** Copy of demand and capacity graphs. Record of escalation.
Theme: Performance Monitoring	**Medium Priority** Control Operation	**Officer: Helen Hathaway, Cardiology Service Lead** **Date: April 2025**

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.

Disclaimer

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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.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Additional Learning Needs Legislation

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2425-19
Fieldwork	December 2024 – February 2025
Executive Sign Off	27th February 2025
Audit Committee	March 2025
Executive Lead	Claire Roche, Director of Midwifery, Women and Family Health
Audit Team	Ian Virgill, Head of Internal Audit
	Warren Alexander, Principal Auditor

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GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau

Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership

Audit and Assurance Services

Executive Summary

Purpose

Our review of the Additional Learning Needs Legislation was completed in line with the 2024/25 Internal Audit Plan for the Powys Teaching Health Board (PTHB, the 'Health Board').

The additional learning needs (ALN) system supports children and young people aged 0 to 25 in Wales with ALN and replaces the special educational learning needs (SEN) system. The ALN system is being implemented over a four-year period, which concludes in August 2025.

The ALN legislative framework was created by the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALNET Act, ALN Act), the Additional Learning Needs Code for Wales 2021 (the ALN Code) and regulations made under the Act.

The Act became lawful from 2021, but implementation is being phased in over a four-year period. In accordance with Section 61 of the Act, Local Health Boards must have a Designated Education Clinical Lead Officer (DECLO) for co-ordinating the Board's functions in relation to children and young people with ALN.

Chapter 9 of the ALN Code details their specific roles and responsibilities. The Act also continues the existence of the Special Educational Needs Tribunal for Wales, which hears and decides appeals and applications in relation to children and young people who have or may have ALN but renames it the Education Tribunal for Wales.

Overview

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

- Collaborative Governance arrangements for the partnership are insufficiently robust.
- Whilst training exercises have taken place, currently there is no formal training programme in relation to ALN operating within PTHB.
- The partnership's Work Plan has not been subject to adequate monitoring or scrutiny.
- Data validation processes are ongoing with respect to the case management system and therefore assurances cannot yet be placed on the accuracy of data contained within it.

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

- The Terms of Reference belonging to the ALN Integrated Steering Group (AISG) lists attendees from all partner organisations. Agendas and action logs are produced but records of attendees have not been maintained.
- A multi-agency Strategic Plan has been produced by Powys County Council (PCC) on behalf of the partnership, but there is no evidence that PTHB was involved in the process. Efforts should be made to ensure that the Health Board is able to demonstrate its input to the ALN and Inclusion Strategic Plan where possible.
- Outcome monitoring procedures are yet to be developed. The establishment of effective outcome monitoring procedures should be raised with the ALN Integrated Steering Group.
- Performance monitoring procedures are yet to be developed. Performance monitoring procedures should be defined in consultation with the Women and Children's Quality and Performance Group.
- A Standard Operating Procedure has been produced in respect of the Health Board's Duties in relation to the ALN Tribunals process; the document has been submitted to the AISG for approval / ratification but has not yet been approved.

Scope & Assurance Summary

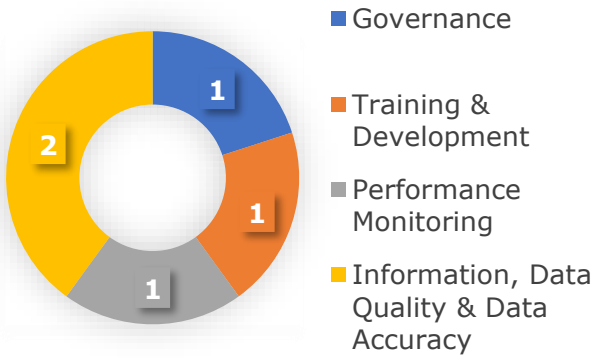
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	1	**Reasonable**
2	There is sufficient training and engagement with staff.	2	**Limited**
3	Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	3	**Limited**
4	There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	4, 5	**Reasonable**
5	There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	4	**Reasonable**
6	There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal.		**Substantial**
7	Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met.		**Substantial**

Management Actions

2 High Priority

3 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	**Reasonable**

An ALN Integrated Steering Group has been established in partnership with Powys County Council and Neath Port-Talbot Group of Colleges. A Strategic Plan and a Strategic Priorities Work plan in relation to the partnership have been produced.

A Standard Operating Procedure has been produced in relation to the Health Board's duties under the ALN Act for the purposes of providing guidance to staff.

No current staffing or capacity issues have been reported, although the potential exists for future increases in demands upon the service as the legislation becomes more established.

Governance arrangements have been documented in relation to the partnership insofar as senior representatives of each partner organisation are listed in the AISG Terms of Reference, but a lack of accountability was indicated with respect to actions contained in the work plan and this may have a detrimental impact on the effectiveness of the group. Clearly documented governance and escalation arrangements exist within PTHB, but the means by which the partnership itself is subject to overall scrutiny have not been clearly defined. **(Key Finding 1).**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance Arrangements** Responsible individuals have been designated within each partner organisation but robust collaborative working governance arrangements are yet to be established.	Failure to comply with legislation resulting in a reputational risk, additional Welsh Government scrutiny, wasted financial and staff resource.	**Agreed Action:** An agenda item will be raised at the ALN Integrated Steering Group with the intention of establishing more clearly defined governance arrangements in respect of the partnership working arrangements. It will be requested that the newly established governance arrangements are employed to ensure that the strategic plan and actions listed within the work plan are subject to a documented approvals process and that monitoring procedures are established in order to address outstanding actions.
			Expected Evidence of Implementation: ALN Integrated Steering Group Minutes. Updated TORs to reflect updated Governance arrangements.
		Medium Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health **Date:** September 2025
	Theme: Governance	Control Design	

Objective 2: There is sufficient training and engagement with staff.	**Limited**

Several guidance documents, including detailed procedure notes, flowcharts and presentations have been produced in order to provide information to Health Board staff in relation to the requirements of the ALN Act. Emphasis is placed on the procedures Health Board staff must follow in order to ensure compliance with the Act.

Training materials are available, and we were informed by the DECLO that some training exercises have taken place in order to provide Health Board staff with information about their responsibilities under the new legislation. An audit of staff knowledge and confidence has been carried out but it does not appear that any actions have been implemented. A training schedule has not been established, and training records have not always been maintained. **(Key Finding 2).**

Key Findings		Risk & Impact	Agreed Management Action
2	**Training** The DECLO has undertaken some training initiatives and offers individual assistance to colleagues who require guidance in relation to ALN issues but a formal or regular training programme is not currently in place.		**Agreed Action:** Training initiatives will be revisited; a training schedule will be produced, informed by existing or refreshed data about staff knowledge and confidence, and details of training availability will be made available to relevant staff. Records will then be maintained of attendance at completed training.
			Expected Evidence of Implementation: Training schedule. Training records.
		High Priority	**Officer**: Designated Education Clinical Lead Officer / Assistant Director for Women and Children's Services
	Theme: Training & Development	Control Design	**Date:** September 2025

Objective 3: Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	**Limited**

Partnership arrangements have been established with relevant stakeholders in the ALN Integrated Steering Group, and some collaborative work has taken place in relation to a joint 'Strategic Priorities Plan'. Outcomes in the plan were appropriate, but in some cases were found to lack clarity in that intended actions have not always been documented. Target dates either have not been listed, are ambiguously defined, or have elapsed. **(Key Finding 3).**

Each partner's operational case management responsibilities are clearly defined and protocols for communicating with service users have been documented.

An 'ALN and Inclusion Strategic Plan 2024-2030' has been produced, although this was led by Powys County Council with only limited input from the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
3	**Strategic Priorities Plan Monitoring** A plan is in place, and whilst listed outcomes were appropriate, some were found to be unclear in terms of the means by which they are to be achieved. Target dates either have not been listed, are ambiguously defined, or have elapsed.	Ineffective arrangements resulting in wasted resources, failure to deliver strategic objectives, poor service user experience, and additional scrutiny from Welsh Government.	**Agreed Action:** Monitoring procedures in relation to the partnership's Strategic Priorities Plan will be reviewed and it will be ensured that regular reports are made at an appropriately senior level, with reference to the reviewed governance arrangements specified in Key Finding 1.
			Expected Evidence of Implementation: Work Plan progress reports.
		High Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health
	Theme: Performance Monitoring	Control Design	**Date:** September 2025

Objective 4: There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	**Reasonable**

A case management system 'ALN App' has been developed and is currently in the later stages of implementation. Once fully implemented, this will enable ALN requests and referrals to be recorded accurately, and for relevant data to be captured and made available to stakeholders such as the DECLO. However, there have been implementation issues surrounding the system, principally relating to ensuring all relevant data is input where necessary. Efforts are currently underway to ensure that all relevant data is captured within the system and a framework for monitoring compliance data is being implemented. **(Key Finding 4).**

It is also of note that data regarding the Health Board's duty (under Section 64 of the ALN Act) to notify the parents / carers of a preschool child and the responsible Local Authority in cases where the Health Board identifies that the child is likely to have ALN is not currently available. The system through which such notifications take place and the dataset associated with this are being finalised. **(Key Finding 5)**

Access arrangements to 'Tyfu', a system administered by PCC which contains service users' Individual Development Plans (IDPs) have been established for Health Board staff. Guidance is available to staff who are responsible for contributing to the IDPs.

Case outcomes are evaluated on an individual basis as part of the wider ALN processes but monitoring procedures in order to identify themes and trends in this area are yet to be developed.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Data Validation** Data validation exercises are being undertaken but assurances cannot yet be made with respect to the completeness of data contained in the ALN App.	The health board does not comply with its statutory responsibilities resulting in children failing to access the support that they need leading to poor outcomes.	**Agreed Action:** Data validation exercises will continue and regular compliance reports will be made to the Planning, Partnerships and Population Health Committee. **Expected Evidence of Implementation:** Reports to the Planning, Partnerships and Population Health Committee.
		Medium Priority	**Officer: Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health** **Date: December 2025**
	Theme: Information, Data Quality & Data Accuracy	Control Design	

5	**Section 64 Notifications** The system by which notifications of suspected cases where additional learning needs have been identified and are issued to parents / carers and the Local Authority is yet to be established.	The health board does not comply with its statutory responsibilities resulting in children failing to access the support that they need leading to poor outcomes.	**Agreed Action:** The system will be finalised and validated. Progress reports will be made in the ALN Update to the PPPH Committee. **Expected Evidence of Implementation:** Reports to the Planning, Partnerships and Population Health Committee.
		Medium Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health **Date:** December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 5: There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	**Reasonable**

Higher level performance monitoring and quality assurance procedures across the partnership are still being developed. This is being addressed by the ALN Integrated Steering Group.

The principal risks to the Health Board relate to compliance in areas directly under its control; the dashboard of the case management system incorporates key parameters in relation to the Health Board's compliance with the requirements of the ALN Act in order to expedite monitoring processes.

The dashboard is regularly monitored by the DECLO, and whilst there have been some inconsistencies during the implementation stage of the new systems (Finding 4), monitoring activities and investigations into inconsistencies have been taking place in order to ensure that data is being captured correctly.

Objective 6: There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal.	**Substantial**

The 'Putting Things Right' process is in place to manage complaints in relation to the Health Board's ALN provision, which would be received by the same means as other Health Board complaints. Details of the process are available on the PTHB website.

A procedure has been established to ensure the DECLO will be notified of any complaints relating to the Health Board's ALN provision, the details will then be reviewed to ensure there are no compliance issues which relate to the ALN legislation. The DECLO would provide input only where concerns with potential compliance issues are identified.

No specific concerns relating to the exercise of the Health Board's functions under the ALN Act have been received. The anticipated volume of complaints is limited and will be dealt with on a case-by-case basis through the standard Putting Things Right process and including oversight by the DECLO.

The ALN Act provides for children, their parents and young people to challenge decisions about ALN, ALP and related matters by way of appeal to the Tribunal.

Information in relation to the tribunal process is not routinely provided to service users and details in relation to it have not been included in the contents of the Additional Learning Needs homepage of the PTHB website. This would instead be provided to complainants during the course of the complaints process. This is an intentional policy decision in order to reduce the likelihood of service users referring complaints to the Tribunal service prematurely. There are other provisions within the ALN Code which make recommendations intended to [avoid the] 'more formal and burdensome route' of a Tribunal.

Appeals to Tribunal are made against the education body, not against the Health Board. Even in cases where the concerns relate to NHS provisions, the appeal would be raised against the education body.

PTHB have previously been involved in tribunals and a Tribunals Standard Operating Procedure ('NHS Participation in Appeals to Education Tribunal Wales: Standard Operating Procedure') has been produced to improve the process for PTHB's involvement though this has not yet been formally ratified through the AISG.

Objective 7: Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met.	**Substantial**

Governance arrangements within PTHB in relation to ALN are satisfactory. Oversight is provided by the Women's and Children's Quality and Performance Group and the Planning, Partnerships and Population Health Committee. Detailed reports have been provided at appropriate intervals during the implementation stages of ALN.

The risks relating to ALN are periodically reviewed by the Planning, Partnerships and Population Health Committee. Senior Executives, including the CEO of the Health Board have provided input into the reporting process.

The DECLO possesses all of the requirements for the role as specified by the ALN Code, and there is a documented escalation procedure within PTHB which is also compliant with the code.

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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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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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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Patient Flow and Discharge Management

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Review Reference	PTH-2425-06
Fieldwork	October 2024 – January 2025
Executive Sign Off	27th February 2025
Audit Committee	March 2025
Executive Lead	Elaine Lorton, Executive Director of Operations, Community and Mental Health.
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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 overall objective of the audit was to review the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team.

Overview

Providing safe, timely and effective discharge for every person who attends hospital is essential, however due to the ageing demographic and an increasing number of older patients being admitted, the complexity of the discharge planning has increased.

The Welsh Governments (WG) 'Hospital Discharge Guidance' issued in September 2024 sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. The principles and processes that support effective discharge are set out in the Discharge to Recover then Assess (D2RA) Pathways Guidance. All patients with a decision to admit to hospital should be assessed and provisionally allocated to one of four pathways.

The national 'Six Goals for Urgent and Emergency Care Programme' sets out the expectations for the Health Boards and their partners for the delivery of the right care, in the right place, first time for physical and mental health. It outlines six goals to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care. The goals include:

Goal 5 – Optimal hospital care and discharge practice from the point of admission.

Goal 6 – Home first approach and reduce the risk of readmission.

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

- The Community Hospital Discharge policy is outdated and requires revision to align with the Welsh Government's 'Hospital Discharge Guidance' released in September 2024.
- Staff members are required to retake the D2RA training course to guarantee full compliance and to ensure that their records are updated in the ESR system.
- Staff members comprehension of Red2Green (R2G) days did not completely align with the guidance provided by Welsh Government. Additionally, the recording of R2G days within the DigiFLO whiteboards indicated that the wards included in the sample were not effectively updating or utilising the R2G feature.
- We were unable to locate adequate evidence within the current systems to explain the rationale behind the decision regarding the D2RA Pathway.
- A Clinical frailty Score for patients over 65 does not form part of the patient assessment on admission to the Community Hospitals.
- The remaining six key findings are operational in nature and include the utilisation of DigiFLO whiteboards, use of Inpatient Notes within WNCR, and delays in setting an estimated date of discharge.

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

- Pharmacy are not always in attendance at MDT meetings.
- User Access Guidance for the Patient Flow List has been prepared and is currently under review by the Local Authority for approval. Once finalised, it needs to be included as an Appendix to the Integrated Patient Flow SOP.
- A comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial.
- Identifying the attendees of meetings proved challenging due to the absence of this being documented.
- There were limited instances of delays in the identification of a Powys Plan pathway for patients in the Wye Valley Trust.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	1,2	**Reasonable**
2	Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	3	**Reasonable**
3	Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	4,5,6,7,8,9,10,11	**Limited**
4	The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	10,11	**Reasonable**
5	Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.		**Substantial**
6	Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.		**Substantial**

Management Actions

2 High Priority

9 Medium Priority

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Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	**Reasonable**

Overview / Summary of Observations

There are three established policies and procedures governing Patient Flow and discharge management: the 'Community Hospital Discharge Policy & Procedures', the 'Management of Reluctant Discharge procedure', and the 'Integrated Patient Flow Standard Operating Procedure' (SOP). The Management of Reluctant Discharge procedure was released in June 2024, aligning with the WG guidance. However, the Integrated Patient Flow SOP, issued in July 2024, has become outdated due to recent changes in certain processes. Additionally, it is important to note that the Community Hospital Discharge Policy is out of date, with its last review occurring in January 2018.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Out of date 'Community Hospital Discharge Policy & Procedures'.** The Health Boards 'Community Hospital Discharge Policy & Procedures' (GNP042) is outdated and does not include the specific requirements and processes that are detailed in the September 2024 WG hospital discharge guidance. The WG document is key to patient flow and sets out the guidance on Hospitals Discharge standards for health, social care, third and independent sector partners in Wales. The update to the Health Board's Hospital Discharge Policy & Procedures will need to incorporate all the necessary elements of the guidance to ensure the delivery of optimal outcomes is fully addressed. For example, D2RA, SAFER, REDtoGREEN and Prevent Deconditioning. Including a 'Planning your Discharge' Letter as an appendix to the Policy would also be advantageous Powell Bethan 06/03/2025 16:45:58	If detailed policy and procedures are not in place, the principles set out in the WG guidance may not be adhered to.	**Agreed Action:** Develop an updated 'Community Hospital Discharge Policy & Procedures', incorporating all relevant information from the September 2024 WG hospital discharge guidance. Once the Policy has been developed, staff will be made aware of its existence, and it will made accessible to staff via the intranet pages. **Expected Evidence of Implementation:** GNP 042 Community Hospital March 2025 - revision in process of being uploaded to intranet Minutes of Bi Monthly Operations - Minutes of approval for the above in CSG ops
		High Priority	**Officer:** Claudia O'Shea **Target Implementation Date:** 1/4/25
	Theme: Policies & Procedures	Control Design	

2	**Update the Integrated Patient Flow SOP.** The Integrated Patient Flow SOP (GNP 088) documents the overarching approach adopted by the Health Board and Powys County Council (PCC) to ensure appropriate flow of Powys residents, both in the Community Hospitals and bordering District General Hospitals. The procedure references the WG Six Goals for Urgent and Emergency Care (with a hyperlink to the relevant document on page 8) and also mentions the D2RA model and Hospital Discharge Guidance. However, the hyperlink for the D2RA pathway incorrectly directs to the Six Goals Policy, whereas it would be more appropriate to link the 'Delivering optimal outcomes and experience for people in hospital'. The link to the Hospital Discharge Policy also needs to be updated once the Policy has been developed. This SOP is primarily operational in nature, emphasising governance, reporting on Pathways of Care Delays and Census, as well as system escalations. Recent modifications to several of these processes have occurred and the policy requires an update to align with the new Patient Flow List which was introduced on 21st October 2024. Additionally, it should include the new Ready to Go units and the governance related to user access for SharePoint.	Incorrect details in the SOP could compromise compliance with the principles established in the WG guidance.	**Agreed Action:** Revise the Standard Operating Procedure to incorporate the recent modifications to several processes and verify that all links are functioning properly. **Expected Evidence of Implementation:** Revision and publication of SOP
		Medium Priority	**Officer:** Senior Nurse Patient Flow **Target Implementation Date:** 1/4/25
	Theme: Policies & Procedures	Control Operation	

Objective 2: Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	Reasonable

Overview / Summary of Observations

Meetings were conducted with the Discharge Coordinator and the Nurses in Charge of both Y Bannau Ward and Epynt Ward. During these discussions, they demonstrated their familiarity with the location of the Discharge Policies and provided explanations regarding the D2RA concept.

D2RA videos are available on the intranet, and staff have undergone training provided by the national team. To promote awareness of this training, posters have been placed in the wards, and a dedicated SharePoint page for D2RA and Optimal Hospital Flow has been established. This page features the latest Welsh Government Hospital Discharge Guidance and the Management of Reluctant Discharge/Transfer of Care document. It also guides staff to the D2RA training modules that were incorporated into the ESR system in June 2023.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Compliance with D2RA module within ESR** A request for a list of staff who have completed the D2RA course revealed that only one individual had done so. The USC Senior Manager clarified that some staff completed the training before the D2RA module was launched on ESR. Consequently, a request has been sent to all staff to retake the course to ensure their records are updated in ESR. There is no specific deadline for retaking this module, but discharge remains a regular agenda item in their internal meetings. Furthermore, bi-monthly meetings are held with Ward Staff. Although this training is not formally structured, it includes updates on policies and encourages discussions about the impact of these changes on patient care.	Insufficiently updated records could lead to incomplete training documentation, which may have implications for compliance.	**Agreed Action:** Establish a specific timeframe for staff to retake the course, ensuring accountability and timely compliance. Monitor training progress and follow up with staff who have not yet completed the module. Consider using the existing bi-monthly meetings to emphasise the importance of the training, address questions, and provide support for those retaking the course.
			Expected Evidence of Implementation: ESR Monitoring in place with minuted bi monthly meetings with training as a standard agenda. To discuss and agree timeframes with HoN & Clinical Service Managers
		Medium Priority	**Officer:** Clinical Service Managers
	Theme: Training & Development	Control Design	**Target Implementation Date:** Quarter 3 2025

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Objective 3: Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	Limited

Overview / Summary of Observations

The WG Hospital Discharge guidance offers detailed insights into the tasks, standards, and expectations applicable to different teams and departments. In our audit review, we assessed the processes in place at the ward level at Y Bannau and Epynt Ward at Brecon War Memorial Hospital to evaluate whether the Health Board had established appropriate practices for the effective implementation of the D2RA Pathways.

We were informed that early morning and afternoon huddles are not conducted on the wards, however, a handover occurs prior to the commencement of each shift. The handover notes do not contain any reference to the D2RA pathway for the patient, nor do the action notes specify whether the patient is classified as a red or green day.

Multi-disciplinary Team (MDT) meetings are conducted weekly in each of the wards included in the sample testing. For the 12 patients reviewed, the attendees at these meetings were considered appropriate. However, there was no evidence of Pharmacy attendance at any of the MDTs, which could potentially lead to delays in the administration of take-home medications.

WG guidance states that in order to minimise any delays to recovery and discharge the Red2Green (R2G) process must be adopted at all times. Although we can evidence the recording of R2G on the manual whiteboards and the DigiFLO whiteboards, staffs' comprehension of R2G days did not completely align with the guidance provided by Welsh Government.

The decision around how the D2RA Pathway was decided, and how the rationale is conveyed from ward to a discharge co-ordination hub is unclear. Also evidencing how the family/ careers have been informed of this decision is also uncertain.

The organisation employs three methods for documenting electronic data related to Patient Flow; The Welsh Nursing Care Record (WNCR), the DigiFLO whiteboards and the Patient Flow Microsoft List database, which is managed by the Local Authority and is accessible to various staff members at USC Powys.

Before conducting our ward visits, we extracted the essential principles from the Welsh Government guidance and evaluated them against the patients in our sample. A number of issues were identified, which have been highlighted under key findings 7,8, 10 and 11.

Further testing was conducted on patients with complex discharge needs to determine whether their discharge was manged efficiently and promptly. Identifying the locations of blockages within the process was difficult due to the notes in Patient Flow. There was frequently a lack of clarity regarding when the assessments were sent to the Complex Care Team, if the documentation was returned for further information and when panel approval was obtained.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Red2Green Process** The R2G standard has been integrated into the DigiFLO application and by default, all patients are categorised as red, requiring staff to manually update their status to green each day. Staff members comprehension of R2G days did not completely align with the guidance provided by Welsh Government.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Provide clear, step-by-step guidance for staff to fully understand the "Red2 Green Process" and how to correctly apply it using both the manual and electronic whiteboards. Conduct refresher training sessions for staff to ensure they fully understand the process. Incorporate the D2RA pathway and R2G standard to the handover documentation.

	All patients listed on the DigiFLO Whiteboards for Y Bannau Ward and Epynt Ward were indicated as having a red day. This suggests that staff may not be adequately updating or using the R2G feature on the DigiFLO application. Furthermore, the manual boards are showing discrepancies, with some patients recorded as having a Green Day, leading to inconsistent reporting. It was also noted that the handover notes prepared before each shift currently lack references to the D2RA pathway and do not specify whether the patient is categorised as a red or green day. Integrating this information into the handover notes, can ensure that all staff members are well-informed and can effectively contribute to maintaining the appropriate pathway, promoting an increase in green days.		**Expected Evidence of Implementation:** Concordance with boards and compliance of D2RA R2G demonstrated with reporting nationally
		High Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Quality, Safety & Patient Experience	Control Design	
5	**How the D2RA Pathway is decided and communicated** The Hospital Discharge guidance from WG emphasises there must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub, to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway. Furthermore, once the decision of the definitive discharge pathway has been agreed, the patient and their family or unpaid carer and existing care providers must be informed and be provided with details of the decision. We could not find sufficient evidence within the existing systems to clarify how the decision regarding the D2RA Pathway was made. Additionally, the communication of this rationale from the ward to the discharge coordination hub remains unclear. It is also uncertain how families and caregivers have been informed about this decision.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Establish a standardised procedure for recording the decision-making process related to the D2RA Pathway, ensuring that the rationale and supporting evidence are clearly outlined. Additionally, document how families and caregivers have been informed about these decisions within the appropriate systems.
			Expected Evidence of Implementation: D2RA pathways recorded on Digiflow with HB wide compliance which feeds into national reporting Documentation on WNCR to reflect family discussions
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

6	**Utilisation of DigiFLO whiteboards** The DigiFLO whiteboard app can be installed on phones, tablets, laptops, and large screens, with nine wards currently equipped. It replicates manual whiteboard processes but faces information governance challenges, particularly maintaining an audit trail to track changes. Currently, large screens are accessible to all staff, but generic accounts only allow display access. Modifications require logging in with individual identification on a computer. Future plans include tap-to-login or PIN systems to enable broader access, including bank and agency staff. The current utilisation of the DigiFLO whiteboards is mixed with some departments still relying on manual whiteboards, as observed during the audit of the two wards.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Conduct targeted training and engagement sessions for departments still relying on manual whiteboards to demonstrate the benefits of the electronic whiteboard and address barriers to adoption. Expedite the implementation of a secure tap-to-login or PIN-based system to ensure accurate tracking of user actions while improving accessibility for all staff, including temporary personnel. **Expected Evidence of Implementation:** Utilization flow boards for all wards with user access, log ins, ability to audit data and bank and agency staff to access removing barriers to access. Ability to confirm access to all with IG barriers resolved for usability and visibility.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
7	**Clinical Frailty Score** The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigiFLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigiFLO whiteboards will be updated accordingly once this new score is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Utilise the DigiFLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack. **Expected Evidence of Implementation:** Clinical frailty scores as part of the output and recording function for DigiFlow.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 4 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

8	**Use of Inpatient Notes within WNCR**
	
	Within WNCR, there is a dedicated section for Inpatient Notes that allows users to select a 'note type' when updating entries, depending on the contributor or content being added. Available options include MDT Review, and Discharge discussions. The admission details and the estimated Date of Discharge (EDD) is also recorded in the system.
	
	As part of the sample testing, we examined the Nursing Notes and although it provided insights into patient mobility, nutrition, and assistance needs, the information could better align with the Hospital Discharge guidance. The notes should include indicators of whether a patient is experiencing a red or green day and the rationale behind this, thereby demonstrating that the R2G framework has been considered and discussed. Currently, the information provided is limited.
	
	Furthermore, the discharge discussion notes section within the Inpatient notes is infrequently utilised, with only three instances identified out of twelve.
	
	As highlighted in key findings 5 and 11, fully utilising WNCR to record all key information would enhance documentation practices and establish a more comprehensive audit trail.
		Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:**
			
			Establish a step-by-step guidance on what should be recorded within the Inpatient Notes under each specific 'note type' so that the information recorded is better aligned with the Hospital Discharge Guidance. The guidance should cover the following:
			
			• Highlight the key elements of the guidance that must be reflected in the Nursing Notes (e.g., indicators of R2G days, rationale for observations).
			• MDT Review Notes to include how the decision regarding the D2RA Pathway was made and communicated to patient and family. (Key Finding 5)
			• Enhance Discharge Discussion Notes by including key information, such as:
			  ○ What was discussed with the patient or their family, including discussions around EDD. (Key finding 10)
			  ○ Date the 'Planning your Discharge' Letter was issued and to whom it was issued. (Key Finding 11)
			
			After the guidance has been established, inform staff about its availability.
			
			Expected Evidence of Implementation:
			
			Update of WNCR user notes for guidance on the above completion (CNO Informatics) will need discussion with national team who control WNCR inputs.
			
			Implementation and monitoring of completion with Community Service Managers of PTHB Community Hospitals if above agreed.

	Theme: Information, Data Quality & Data Accuracy	**Medium Priority** Control Operation	**Officer:** Emma McGowan, Chief Nursing Information Officer **Target Implementation Date:** Quarter 3 Scoping & implementing into WNCR / Quarter 4 to implement into practice
9	**Patients with complex needs** Patients categorised under Pathway 3 present complex needs. Those who are either CO or Discharge Ready and require Nursing Care must undergo a DST assessment or a PAN assessment by the appropriate ward. The findings should be sent to the Complex Care Team for review and submitted to the panel as needed.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Improve documentation practices by implementing a standardised template or clear guidelines for recording and tracking key dates, such as when assessments are forwarded to the Complex Care Team and when panel approvals are granted. This will enhance transparency and traceability and help to identify themes and trends.

	We reviewed 24 patients on Pathway 3 and identified that four had a length of stay exceeding 100 days. Two of the four assessment documents for these patients took longer than 30 days to be completed and forwarded to the Complex Care Teams, with one extending up to 60 days. Additionally, we examined the time from the decision to assess the patient (when patient is CO) to the testing date (18/12/24). All four assessments exceeded 90 days, and two patients have been discharge ready since October 2024. Determining the locations of blockages within the process proved challenging based on the notes in Patient Flow. It was often unclear when the assessments were forwarded to the Complex Care Team or when they received panel approval. Accurately documenting these dates will enable management to determine whether delays originate from the wards or the Complex Care Teams. The Health Board, however, has recognised existing quality issues with the documentation sent to the Complex Care Team, and training needs have been identified to address these concerns.		Explore alternative systems like DigiFLO or WNCR for recording and tracking key dates, as access to Patient Flow is limited to specific staff members. Conduct targeted training sessions for Ward staff to address quality issues in the documentation submitted to the Complex Care Team.
			Expected Evidence of Implementation:
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow Quarter 3 2025
	Theme: Training & Development	Control Operation	**Rhian Price Evans –** CHC Training Quarter 2 2025 **Target Implementation Date:** As above

Objective 4: The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	Reasonable

Overview / Summary of Observations

Wye Valley Trust (WVT) use three methods for documenting electronic data relating to Patient Flow. These methods include the Wye Valley system, the daily live list, which is an Excel document, and the Patient Flow list. A daily live report is generated from the Wye Valley system, capturing all patients registered with a GP in Powys. This information is then exported into the Excel document.

An email is distributed to recipients from Powys Teaching Health Board and Wye Valley, including senior managers, nursing staff, and members of their Care Transfer Coordinators (CTC) team. This communication outlines patients awaiting assessment from a local authority standpoint, highlights individuals who may qualify for the 'Ready to Go' unit, and specifies which patients are palliative and set for discharge today and tomorrow. The email also includes the 'daily live list' for information. This procedure offers a thorough overview of forthcoming discharges and incoming patients. This process is repeated again in the afternoon to ensure that all individuals are informed of any updates.

The Estimated Discharge Date (EDD) is determined during the Multidisciplinary Team (MDT) meetings, which occur daily, and in certain wards, twice a day. While the objective is to establish this date within 24 hours of a patient's admission, the decision is often influenced by the patient's complexity and can sometimes delay the outcome or they provide a preliminary estimate, which may evolve as the patient's journey progresses.

The D2RA care pathways are not implemented in WVT; however, a comparable pathway system is in place for each patient. For instance, Pathway 0 is designated for those returning home, while Pathway 1 caters to reablement or those with slightly elevated needs. Pathway 2 involves admission to a community hospital, and Pathway 3 addresses more complex cases.

The CTC attend daily meetings with social workers and a coordinator from the local authority, which is kept small for efficiency. During the meeting, each participant provides updates. The LA coordinator meets with brokerage beforehand to gather information on assessments and discharge dates. If a discharge date is set, the CTC will inform the ward and arrange the transfer home or to a nursing home by 4:00 PM. Additionally, the CTCs will coordinate transport and provide contact numbers for handovers, whether nurse-to-nurse or doctor-to-doctor. Any changes to the patient journey is documented on all three systems. Alongside the daily meetings, a Delay in Transfer of Care (DTOC) meeting is held every Tuesday. This meeting brings together all CTCs and local authorities, providing a platform for Senior Managers to participate and present challenges.

A sample of the 'daily live lists' was received and evaluated. However, we were unable to compare this data with the Patient Flow List, as the Patient Flow List is a live system, making retrospective analysis impossible.

	Key Findings (Relating to Objectives 3 and 4)	Risk & Impact	Agreed Management Action
10	**Estimated Date of Discharge (EDD)** **Powys Community Hospitals** As part of the sample testing, we compared the EDD recorded on the manual whiteboard to those documented in the WNCR. We identified three instances within Epynt Ward where the dates did not align. Additionally, we examined the interval between the admission date and the date when the original EDD was established. Across both wards, we discovered six cases where the EDD was set more than seven days post-admission, with the longest delay being 51 days.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Clear guidance on the management and recording of EDD needs to be established. Each patient should have an agreed-upon EDD confirmed during their initial Multidisciplinary Team (MDT) meeting or within 24 hours of admission, which must be documented and communicated to the patient and their family or caregivers. Any discussions or modifications regarding the EDD should occur and be recorded prior to the expiration of the original EDD.

It is common for the EDD to be adjusted based on changes in patient needs and their progress in rehabilitation. Out of 12 patients, five had their EDDs modified from the original dates. Notably, for two of the five, the amendments recorded in WNCR occurred after the original EDD had lapsed, with one instance being 38 days later. It is essential that the EDD is discussed with both the patient and their family; however, we were unable to locate any documentation of such discussions in the In-Patient notes under the MDT Review, or discharge discussion records. (key finding 8). **WVT** We tested a sample of 38 patients, 12 had an estimated discharge date (EDD) set within 24 hours of admission. The remaining 26 patients did not have an EDD within that timeframe, with 8 patients still lacking an EDD after 4 days, and one patient waiting up to 7 days. While 68% of patients did not receive an EDD within 24 hours of admission, we recognise that there may be valid reasons or factors contributing to this situation. For instance, • There are currently two CTCs operational. If one is absent from the office, the inclusion of the EDD in the daily live list may be affected by the volume of new admissions and overall workload. Although the EDD has been identified in the WVT system, the CTCs have not yet had the opportunity to update the list accordingly. • There may be instances when WVT are at full capacity upon the admission of a Powys patient, resulting in them being allocated a bed within the boarding bays. Consequently, the CTCs will not be informed of this patient until they visit the wards, as the patient is not officially assigned a 'bed'. • Delays in receiving MRI results, especially for stroke patients, can hinder timely decision-making regarding the expected EDD. The CTC team is aware of these delays in the process and is actively working to enhance the situation.		**Expected Evidence of Implementation:** EDD guidance recording to be reflected in Digiflow SOP & recorded as a reporting output measure. WVT evidence, all WVT pts have an EDD with an improved system to identify PTHB pts regardless of bed allocation.
Theme: Information, Data Quality & Data Accuracy	**Medium Priority** Control Design	**Officer: Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow / Chistina Thomas WVT **Target Implementation Date:** Clinical Change Manager (Unscheduled Care) – DigiFlow – Quarter 2 2025 / Chistina Thomas WVT – Quarter 3 2025

11	**'Planning your Discharge' Letter** Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. The Welsh Government Hospital Discharge guidance includes a template for a 'Planning your Discharge' letter, which should be provided to patients. This letter emphasises that discharge planning should already be in progress and outlines the importance of facilitating a quick and safe discharge to enhance the patient's recovery. **Powys Community Hospitals** Our sample testing identified only one instance out of twelve where the system recorded that this letter had been issued. The WG guidance does not specify the appropriate timing for issuing the letter. It is therefore important for the Health Board to decide whether the letter should be provided after the patient's initial MDT review or included as part of the admission pack. Additionally, it would be beneficial to document the issue of the discharge letter in the Discharge Discussions section of the WNCR. (Key Finding 9) **WVT** During discussions with the CTC, it was observed that they do not provide a 'Planning your Discharge' letter to patients and caregivers. The CTC acknowledged that the letter was discontinued due to the outdated policy. However, they expressed their willingness to resume issuing and documenting the letter once the new policy, which incorporates the standard letter, is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Ensure that a 'Planning your Discharge' Letter is issued to each patient. Establish clear guidance on when the letter should be issued. Ensure that the issue of the letter is documented within WNCR system, as highlighted in key finding 9. **Expected Evidence of Implementation:** March 2025 for letter and issuing as part of PTHB Discharge Policy.
		Medium Priority	**Officer:** Senior Manager Unscheduled Care & Community Service Managers
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** Quarter 2 2025

Objective 5: Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.	Substantial

Overview / Summary of Observations

The Integrated Patient Flow SOP is in place to guide this process. The primary data source is obtained from the Patient Flow list, which contains real-time patient information and tracks critical milestones for all admissions throughout their inpatient journey. It also tracks the Pathway of Care Delay (POCD) codes associated with each patient who has been classified as Clinically Optimised, and has exceeded 48 hours without being discharged.

The allocation of POCD codes to patients occurs on Census day during a meeting with the USC Senior Management team and the Local Authority Hospital Patient Transfer Manager. A Joint Validation meeting follows to confirm codes linked to delays, with validation finalised and approved within three days.

After the census submission, the national team will provide a spreadsheet to the Health Board and a dashboard that illustrates the organisation's performance in relation to the national targets. Themes and trends from the census reports, previously reviewed by the now-dissolved Strategic Oversight Group (SOG), are monitored by the POCD Action Plan working group, which meets quarterly. The Management Team uses the dashboard to track delay progress. The Senior Management Group has noted a reporting gap since the SOG's disbandment.

For 2024/25 the Care Action Committee has agreed the following ministerial targets of:

- 15% reduction in total Delays
- 20% reduction in total days delayed
- 20% reduction in delays due to an assessment reason code

In October, the Health Board reported a 21% decrease compared to their baseline for the 15% target reduction in total delays. Additionally, there was a 19% reduction against the 20% target for total days delayed, and a significant 43% reduction in delays attributed to an assessment reason code, surpassing the 20% reduction goal.

Every quarter, the Health Board is required to submit a POCD action plan. This plan outlines their top 1-5 key actions, details their initiatives related to the POCD reason codes, and assesses their progress towards meeting ministerial targets. The WG reviews the plan and offers feedback on the Health Board's latest submission. In August 2024, the WG acknowledged several positive aspects of the July POCD action plan but recommended that the Health Board include in their October submission the progress made during the second quarter to tackle capacity issues resulting from funding decisions. Additionally, they requested more detailed information regarding engagement with the regional Mental Health and Learning Disabilities lead.

A review of the October POCD Action Plan submissions indicates that the Health Board has supplied WG with further information on capacity issues. However, they could not advance engagement with the regional Mental Health and Learning Disabilities leads due to the Strategic Oversight Group being stepped down.

Objective 6: Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.	Substantial

Overview / Summary of Observations

To ensure that there is effective monitoring and oversight of discharge management within the Health Board, Unscheduled Care has established several meetings. These involve executive-led groups, representatives from Powys County Council, and third sector organisations, all collaborating alongside health professionals.

Patient Flow meetings primarily focus on reviewing district general hospitals, community hospitals extended length of stay, whereas the Daily Flow meetings are held to discuss safe care practices, which are escalated to organisational management and reported to the Delivery Coordination Group as needed. Alongside the daily meetings, the team has established the Delivery Co-location Group, tasked with monitoring the advancements of the temporary colocation modifications. Furthermore, they engage in the National Call to communicate the operational pressure levels of the Health Boards to the National Team.

In addition to these meetings, there is the bi-weekly Care Action Committee (CAC), formed in November to tackle the 50-day Integrated Care Winter Challenge initiated by the Welsh Government. This committee has taken the place of the SOG. After reviewing the information presented at the CAC, we are assured that the data previously discussed at the SOG is now being addressed within the CAC.

The POCD Action Plan working group convenes on a quarterly basis, prior to the submission of the updated action plan to Welsh Government. There is a Bimonthly Community Service Group Operational Meeting, which receives updates from each service. It was noted that the Terms of Reference for this meeting was incomplete and remained in draft form. Between April and July 2024, the Lead of Unscheduled Care participated in only one out of three scheduled meetings. Additionally, the meeting in October did not occur, and no subsequent meetings were communicated during the audit.

Before the disbandment of the USC SOG, a monthly highlight report was prepared for the Joint Executive Committee. This report included any unresolved operational issues that could impact service delivery. However, we could not determine whether this practice has continued or if the committee still convenes, as we were unable to obtain evidence of any recent meetings.

It has been noted that while several meetings are recorded in the Integrated Patient Flow Standard Operating Procedure, a comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial. Additionally, identifying the attendees of these meetings proved challenging due to the absence of this being documented.

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.

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the 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.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Archwilio Cymru
Audit Wales

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

Date issued: February 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.

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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 2023-24 Charitable Funds Financial Statements	Executive Director of Finance, Capital & Support Services	Audit of the financial statements to inform the audit opinion.	Audit complete. ISA260 report presented to the Board 29 January 2025.	AGW gave unqualified opinion 30 January 2025
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.	Planning underway. Interim testing of some balances is also underway.	Opinion prior to 30 June 2025

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.	May 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	May 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.	Report in internal clearance	May 2025
Structured Assessment 2024 - Core	Director of Corporate Governance/Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Issued in draft	May 2025 (Board - March 2025)

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
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 to be issued in March 2025	TBC
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.	Project brief to be issued in March 2025	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
Addressing workforce challenges in NHS Wales	February 2025
Cancer Services in Wales	January 2025

Additional information

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

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
Fee Scheme 2025-26 | Audit Wales	January 2025
Audit Quality Report 2024: Strengthening trust in audit | Audit Wales	January 2025

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.

Subject:	Audit Recommendations Tracking (Internal and External Audit)
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Deputy Board Secretary
Purpose:	The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of **27 February 2025**.
Recommendations:	The Audit, Risk and Assurance Committee is asked to: • **CONSIDER** the current position of outstanding Audit Recommendations and take **ASSURANCE** that the organisation has an appropriate system for tracking and responding to audit recommendations.

Executive Summary:	The responsibility for the collation, monitoring and reporting of internal and external (Audit Wales) audit recommendations is the responsibility of the Corporate Governance Team. Information is managed throughout the year and reported to the Executive and Audit & Risk Assurance Committees on a regular basis.
	
	This report was considered by the Executive Committee on 5 March 2025. The report provides the following information:
	
	• Internal Audit Recommendations that:
	  • are OVERDUE
	  • have REVISED DEADLINES
	  • have been COMPLETED since the previous report
	  • are NOT YET DUE for implementation
	
	• External Audit Recommendations that:
	  • are OVERDUE
	  • have REVISED DEADLINES
	  • have been COMPLETED since the previous report
	  • are NOT YET DUE for implementation
	
	The report also confirms there are no outstanding recommendations from Local Counter Fraud Services Pro-Active Exercises.

SUMMARY POSITION – Internal Audit

Internal Audit – Not yet due for implementation

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High	0	0	0	o	0	4	4
Medium	0	0	0	0	0	14	14
Low	0	0	0	0	0	1	1
Total	0	0	0	0	0	19	19

Internal Audit – Completed since last report

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High	1	o	o	o	0	3	4
Medium	2	0	0	2	1	17	22
Low	0	0	0	0	1	1	2
Total	3	0	0	2	2	21	28

Internal Audit – Deadline revised

Internal Audit Priority	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
High	0	1	0	0	1	1	3
Medium	0	1	0	1	1	4	7
Low	0	0	0	0	3	3	6
Total	0	2	0	1	5	8	16

Summary since the last report in February 2025:

- 28 actions have been completed since the last report
- 19 actions are not yet due for implementation of which 4 are high (20%)
- An additional table has been included to provide detail in relation to recommendations with revised deadlines

SUMMARY POSITION – Internal Audit

	Internal Audit – Overdue							
Internal Audit Priority of recommendations		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Total
	High	0	0	1	0	2	1	4
	Medium	1	0	1	0	3	7	12
	Low	0	0	0	0	2	4	6
	Total	1	0	2	0	7	12	22
Internal Audit report Assurance rating	Limited	0	0	0	0	0	1	1
	Reasonable	1	0	2	0	7	9	19
	Substantial	0	0	0	0	0	2	2
	Total	1	0	2	0	7	12	22

Summary

22 actions are **overdue** of which:
- 12 (55%) are from the current financial year
- 7 (32%) are from the last financial year
- 2 (9%) are from 2021/22
- and 1 (5%) is from 2019/20

Completion Status
- 17 (77%) are partially completed
- 5 (23%) have no progress

Priority
- 4 (18%) are high priority
- 12 (55%) are medium priority
- 6 (27%) are Low priority

Assurance rating

- 1 (5%) relates to a limited assurance report
- 19 (86%) relate to reasonable assurance reports
- 2 (9%) relate to substantial assurance reports

Actions being Taken:
- Lead Executives are asked to continue to give priority to the overdue recommendations and provide further updates
- Further updates will be provided to the ARAC Committee in the next report in October 2025.

SUMMARY POSITION – External Audit

External Audit – Completed since last report						
Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	0	0	0	0	4	4

External Audit – Not yet due for implementation						
Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	0	0	0	0	4	4

External Audit – Overdue						
Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	0	0	0	1	1	2

External Audit – Deadline revised						
Year	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Total	0	0	0	1	5	6

Summary since the last report:

- 4 actions have been completed
- 2 actions are overdue
- 4 actions are not yet due for implementation from the current financial year (2024/25)
- An additional table has been included to report recommendations with revised deadlines

SUMMARY POSITION – Internal Audit by Executive Lead/Director

Internal Audit – Overdue/Deadline Revised

Director	Year	No Years Old	Report Title	Audit Assurance Rating			Recommendation's Priority Rating			Overdue Recommendations	Recommendations with Deadline Revised	Total Outstanding Recommendations per Directorate
				Limited	Reasonable	Substantial	High	Medium	Low			
Helen Bushell - Director of Corporate Governance	2425	0	Core Financial Systems – Treasury Management Final Internal Audit Report			x			x	2	0	6
	2425	0	Risk Management and Assurance		x			x	x	0	3	
	2021	**4**	Partnership Governance – Programmes Interface	x			x			0	1	
Pete Hopgood - Executive Director of Finance, Capital & Support Services	2425	0	Capital Systems		x			x		0	1	4
	2425	0	Core Financial Systems			x			x	1	0	
	2425	0	Cleaning Standards		x				x	1	0	
	2324	1	Estates Condition	x				x		0	1	
Claire Roche Executive Director of Nursing, Quality, Women and Family Health	2324	1	Incident Management		x		x	x	x	3	0	7
	2425	0	Patient Experience		x			x		2		
	2425	0	Risk Management and Assurance		x			x		1		
	2425	0	Deprivation of Liberty Safeguards	x				x		1		
Claire Madsen - Executive Director of Allied Health Professions, Health Sciences & Digital	2223	**2**	Therapies and Health Sciences Professional Governance Structure		x			x		0	1	1

SUMMARY POSITION – Internal Audit by Executive Lead/Director

Internal Audit – Remain Outstanding/Overdue

Director	Year	No Years Old	Report Title	Audit Assurance Rating			Recommendation's Priority Rating			Overdue Recommendations	Recommendations with Deadline Revised	Total Outstanding Recommendations per Directorate
				Limited	Reasonable	Substantial	High	Medium	Low			
Elaine Lorton – Director of Primary Care, Community and Mental Health	1920	**5**	Outpatients Planned Activity		x		x			1	0	7
	2425	0	Continuing Health Care and Funded Nursing Care		x		x	x	x	2	4	
Debra Wood-Lawson - Executive Director People & Culture	2324	1	Health and Safety Arrangements		x		x		x	0	3	3
Mezz Bowley - Executive Director of Public Health	2425	0	Winter Respiratory Vaccination Programme		x			x		1	0	1
Nicola Johnson - Executive Director of Planning, Performance & Commissioning	2021	**4**	Winter pressures and flow management		x			x		0	1	6
	2324	1	SLAs for In-reach Medical Staff		x		x	x	x	4	1	
Kate Wright - Executive Medical Director	2324	1	SLAs for In-reach Medical Staff		x		x	x	x	4	1	7
	2425	0	End of Life Care Services		x		x		x	2	0	
Lucie Cornish - Director of Improvement & Transformation	2122	**3**	Dementia Services- Home Treatment Teams		x		x	x		2	0	2

SUMMARY POSITION – External Audit by Executive Lead/Director

	External Audit – Overdue/Deadline Revised					
Director	Year	No Years Old	Report Title	Overdue Recommendations	Recommendations with Deadline Revised	Total Outstanding Recommendations per Directorate
Helen Bushell - Director of Corporate Governance	2324	1	Structured Assessment 2023	0	1	2
	2425	0	Primary Care Follow-up Review	0	1	
Claire Roche - Executive Director of Nursing, Quality, Women & Family Health	2324	1	Structured Assessment 2023	1	0	2
	2324	0	Primary Care Follow-up Review	0	1	
Elaine Lorton - Executive Director Primary Care, Community & Mental Health	2425	0	Primary Care Follow-up Review	0	3	3
Lucie Cornish - Director of Improvement & Transformation	2425	0	Review of Cost Saving Arrangements	1	1	2

Appendices:

The following appendices are provided with more details:

- A – Internal audit - recommendations completed since last report
- B – Internal audit - recommendations not yet due
- C– Internal audit - recommendations overdue
- D – Internal audit - recommendations with revised deadlines
- E – External audit - recommendations completed since last report
- F – External audit – recommendations not yet due
- G – External audit – recommendations overdue
- H – External audit – recommendations with revised deadlines

INTERNAL AUDIT RECOMMENDATIONS COMPLETED SINCE LAST REPORT

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please	PTHB Ref. No.				If action is complete, can evidence be provided upon	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	for Closure Yes/No	Justification for Closure	Update receiv
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Planning & Performance Director of Finance and IT & Director of Primary, Community and Mental Health Services Director of Nursing	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC. 2.3 The CHC Standard Operating Procedures should be aligned with the Scheme of Delegation (Section 12) and practices in Adult and MH&LD CHC should be aligned. The CHC SOP should also be updated to clarify when contract renewals valued over £50,000 p.a. should go through a High Cost Resource Panel. 2.4 The health board should ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for CHC packages across Adult and Mental Health Nursing.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned to be 3-6 months long and commenced in early November 2019. Once the recommendations and/or revised Scheme of Delegation is issued the health board will undertake a review focusing on the recommendations of this report 2.3 CHC Standard Operating Procedure to be updated to ensure the all cases over £50,000 are referred to High Cost Panel 2.4 Formal communication to be issued from the Director of Finance to services leads for CHC (Adult and Mental Health) on the need to ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for all CHC packages. Additionally, to offer support if clarity is required on the Scheme of Delegation or SOP.	des-20		Complete	2	Complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of contracts, Standard Operating Procedures and Scheme of Delegation. This action will be transferred to the Programme's risk register to track to completion. **28/2/2022** Complex Care Project has commenced with Secondment to lead the work and review the requirements in line with the New Framework which is being implemented. Scheme of delegation and sign off procedures are in place and effective. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **06/04/23** - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group **07.02.2024** - S33 group has not been functioning Manager finishing in March. Scheme of delegation has been completed and agreed, however, will now be reviewed under new strategic structure SOP has been updated and agreed in July 2022, scheme of delegation will be added as an amendment. New internal audit underway for CHC working with new Assistant Director in Complex Care **UPDATE 24.12.2024** This work completed in July 2023. An Internal Audit of CHC which produced a final report in May 2024 supersedes this historic work. JWS has discussed with RD - prorposal to close this action.	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	sep-21		43	0	mar-25				20.12.2024
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent inspectorate visits and feedback from the relevant local authority. 3.2 This process should be documented in the CHC SOP (see finding 4 also). In-county care homes monitoring 3.3 The health board should clarify how it receives assurance that the LA has escalated issues identified through the joint monitoring process to the JQAP as appropriate, for example through its representation at the JIMP and JQAP meetings and through feedback to the CCSG. 3.4 The health board's CHC SOP should be updated to make reference to the joint monitoring process under the S33 agreement, including the assurance it receives as per 3.3 (see finding 4 also). 3.5 The above recommendations on in- and out-of-county care homes monitoring should take into consideration the NHS Wales National Collaborative Commissioning Unit project on provider care map dashboards. 3.6 The assurance mechanisms over CHC and FNC packages, including for monitoring both in- and out-of-county care homes, should be incorporated into the Board Assurance	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	apr-20	jul-21	Complete		Complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart for ensuring payment is made. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of checklists, quality dashboard and SOPs. This action will be transferred to the Programme's risk register to track to completion. **28/2/2022** - Escalation of care homes is supporrted via the local Care Home MDT. Assurance checkes part of the QA assessment for out of county placements in place. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **07.02.2024** - Monitoring for out of counties is completedby the main commissioning body for that area. PTHB adhere to governance by reviewing with the area LA and HB or CCG prior to placment. This is also added in to each patients QA documentation. JIMP is a collaborative meeting. Any issues raised are reported via QSEG, CSG by reports completed. Out of county reviews are completed as per National CHC Framework 3/12 and annually. These are then brought back to panel for scrutiny. FNC Payments are completed by finance. Reconciliation is completed by the Complex Care adult general admin under Section 33. **UPDATE 24.12.2024** This work completed in July 2023. An Internal Audit of CHC which produced a final	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	jul-21		51	0	mar-25				20.12.2024
192014	Care Homes Governance	Limited	Director of Nursing, Quality, Women and Family Health	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit. 4.2 The health board should undertake a demand and capacity review in light of the updated processes, in order to ensure compliance with legislation and maintain patient safety.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes. 07.02.2024 Current SOP evidences scheme of delegation, will now be updated to reflect new structure. Processes within adault general and MH/LD are aligned with the development of the same QA document, governance processes. Demand and capacity review has been undertaken and reported to in August 2022	mar-20	apr-21	Complete		Complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 As part of the restructure of the team in CSG betweeen November 2021and January 2022 the service was re mapped against activity and new pathways and a revised service model was implemented. **23.08.2022** - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. **02.02.2023** - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. **06/04/23** - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group **07.02.2024** - AD for Complex Care appointed and undertaking a gap analysis. DDoN undertaking a	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion, reviews completed virtually	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	apr-21		[illegible]	0	mar-25				20.12.2024
222311	North Powys Wellbeing Programme	Reasonable	Director of Improvement & Transformation	Senior Responsible Officer	R5	An updated benefit framework should be developed to ensure clarity and relevance to the phase of the Programme but most importantly to meet with the overall desired outcome of the North Powys Wellbeing Programme	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	des-23		Complete		Complete		Transformation element of the programme was transferred to transformation and value team under ASM for a period. Further work progressed via RIBA 1 to inform facility planning however the outputs of this have not been incoporated into an overaching benefits and outcomes framework due to limited capacity within the time. Team members are back with the programme and work is now being undertaken to develop further the detailed models of care, workforce and financial implications. Benefits and outcomes will be developed per service areas in the autumn and an overarching framework will be put in place with baselines and trajectories. **20/12/24 -** Models of care outputs have been produced from the workshops for phase 1. Further work has been put on hold awaiting decision on WG capital funding. **26.02.2025** - Complete. the North Powys Wellbeing Programme is now taking a phased approach and the Benefits Framework will need to be reviewed in line with the phasing and any associated funding received. We are expecting confirmation from WG imminently on funding for Phase 1 and a benefits framework will be developed alongside the work initiated if funding is received	Capital funding decision is impacting on ability to progress the programme	The capital funding position is escalated to Programme Board.	To be confirmed following approval of the WG funding		15	1502	mar-25	jan-23		20.12.2024	
222321	Performance Management and Reporting	Substantial	Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	R1	Ensure that the Integrated Performance Framework has been fully implemented as planned and is operating effectively.	PTHB has established an IPF implementation group and developed a project implementation plan with the aim of integration by the end of Q3. Key areas of implementation include but are not limited to. • Power BI Performance and assurance dashboard • Performance reporting (Commissioner and Provider assurance framework, Integrated Performance Report, Directorate performance reviews, and Performance and Engagement for key services).	des-23		Complete		Complete		**16/12/24 -** Implementation of the IQPF, approved in September 2022, has been taken forward: - Directorate Performance reviews refreshed and structured around the 4 domains of the IQPF. - Integrated Quality and Performance Report refreshed to provide more detailed narrative on escalations and exceptions, performance trajectories and mitigating actions to ensure performance targets achieved. - IQPG meeting established to provide regular forum for discussion with the services on performance across the 4 domains of the IQPF. Review of learning from IQPGs to be presented to Executive Committee to inform future development. - Work continues on the Power BI supporting solution however is behind timescale. The supporting IT solution has not prevented the rollout of the IQPF. **130225 update** - IPF now the IQPF. - Directorate Performance Reviews have been further refreshed within the Integrated Quality and Performance Group structure, currently being reviewed. - Integrated Quality and Performance Report also refreshed and to be reviewed to include further detail regarding Quality measures within the IQPR. - Work outstanding on the Power BI supporting solution however has not prevented the continued implementation of the IQPF.		The health board is still able to deliver a performance function without the IT solution. A revised timescale for the IT solution is being developed for Executive committee in July 24			15	1502	mar-25				
232417	Primary Care Dental Services - Management and Monitoring of General Dental	Substantial	Director of Primary Care	Assistant Director of Primary Care Services	R1	In the event of the GDS Monitoring Group meeting quoracy levels not being met, future meetings should proceed, and arrangements should be implemented to allow for any decisions undertaken to be approved/ratified outside of the meeting e.g. via Chairs action	Arrangements are in place to allow for decisions to be undertaken and approved outside of the meeting at Assistant Director, Interim Director of Finance, Chief Executive and Chair level, however this is not reflected in the GDS Monitoring Group Terms of Reference. The GDS Monitoring	mar-24		Complete		Complete		TOR updated and will be formally signed off at GDS monitoring Group on 27th June 2024					1	1491	mar-25	mar-24			
232417	Primary Care Dental Services - Management and Monitoring of General Dental Services Contract	Substantial	Director of Primary Care	Assistant Director of Primary Care Services	R2	The GDS Monitoring Group Terms of Reference (ToR), and Primary Care GDS Commissioning Assurance Framework should be updated to reflect the revised Health Board Committee structure and reporting arrangements and incorporate version control to ensure its accuracy of content. These documents should also be updated to state the performance metrics that are submitted to the Delivery and Performance Committee via the Integrated Performance Report.	The GDS Monitoring Group Terms of Reference will be updated to reflect the current Health Board Committee Structure and will include the performance metrics that are reported to the Delivery and Performance Committee via the Integrated Performance Report. Version control of the document will also be introduced. The Primary Care GDS Commissioning Assurance Framework will be updated to reflect the revised Health Board Committee structure reporting arrangements and will include the performance metrics that are reported to the Delivery and Performance Committee via the Integrated Performance	mar-24		Complete		Complete		CAF Dashboard, framework and tolerance level documents updated for 24/25 to reflect the revised Heatlh Board Committee structures and the current performance metrics. Will be approved as part of CAF assurnace documentation signoff at a future GDS meeting.					1	1491	mar-25	mar-24			
242501	Winter Respiratory Vaccination Programme	Substantial	Executive Director of Public Health	Head of Public Health Programmes and Projects/Assistant Head of Public Health Nursing	R1	a) Planning should start with the most up to date primary data. b)The population totals should be agreed at a fixed point in time. c)Population changes should be recorded, and clear auditable trails established. d)Check balances should be embedded to ensure accuracy. e)Spreadsheets should have Standard Operating Procedures to ensure consistency, protection, owner oversight, review periods, and retention	Planning always starts with the most up to date primary data provided by our information team which is based on the planning assumptions provided by VPW. • Population totals will be fixed at the time that the final JCVI advice is given to Health Boards, however before the advice is announced (usually a few weeks before the campaign) the planning assumptions change multiple times requiring multiple planning scenarios. • VPW Planning Assumptions and JCVI advice inform the population changes, however we can record these going forward on the front page of the spreadsheets along with a SOP to ensure consistency, protection, owner oversight, review periods and retention. • Because of the nature of the vaccination programme,	aug-24		Complete		Complete		Front sheet for the spreadsheet completed and being implemented. Primary data is dependant on confirmation of eligibility criteria being published by JCVI and subsequent WHC from WG. Leading up to the publication draft scenarios will be developed and modelled on likely eligibility groups. **19-08-24** - We only have indicative numbers for the Covid-19 programme as of August 2024 that we currently use for capacity planning. This is noted at the front of the spreadsheet. A data refresh is planned by DHCW on or before 1st Sept. Once we have notification that this is completed a final capacity planning document can be completed for Powys **18/12/2024** - Final data received in Sept. No challenges reported when planning. SOP completed.	Late confirmation of JCVI recommendation impacts on planning time **19-08-24** - The awaiting of the data refresh by DHCW. But this does not hinder the planning .	Regular communciation with NHS Executive Vaccine Planning Team on potential announcement of JCVI and current planning assumptions.	aug-24	Yes			mar-25	jun-24			

242501	Winter Respiratory Vaccination Programme	Substantial	Executive Director of Public Health	Head of Public Health Programmes and Projects	R3	The VODG should have an overarching SOP bringing together all reporting functions. SOP should be written for each reporting function and linked into 3.1a. 3.2a) Committee Terms of Reference should be clearly defined, authorised, and include a defined quorum for key participants. 3.2b) Actions should be clearly flagged, have an owner, delivery timeline, and a clear audit trail to the Action log. Closed actions should be linked to the appropriate minutes. 3.2c) Final minutes should be retained in PDF format in a secure folder.	3.1)Action: SOP for the Vaccination ODG and the Powys Vaccination Group to be developed. 3.2)The governance structure for the VODG (monthly) and PVG (Quarterly) has been developed. ToR have been written and agreed for each group. There are escalating processes in place to manage risks and issues. Project groups for each vaccination programme will be established prior to the start of the Winter Respiratory Programme and will report to the VODG initially and PVG and plans submitted to Executive Committee and Board for final approval/information. Action: Review all SOPs and processes for the groups e.g. Risk Management, ensuring remain fit for purpose. Action: Review all vaccine for	jun-24		Complete		Complete	Final TORs for Powys Vaccination Group and Operational Delivery Group in place. Draft overarching document/SOP being developed,and risk /issues log reviewed on 4th June 2024 and being aligned to corproate templates. On track for end of June. **19-08-2024** - A draft overarching SOP has been developed and will be discussed at the PVG in Sept. **18/12/2024** - Overarching SOP devloped - needs to go to next PVG for sign off. Unable to be signed off at last PVG due to agenda but will be prioritised for the next meeting.		There are currently agreed ToR for both the PVG and ODG and both groups are aware of the interactions between them	Final sign off at PVG in early Sept Sign off will now be next PVG in Jun 25	Yes			mar-25	jun-24	
242501	Winter Respiratory Vaccination Programme	Substantial	Executive Director of Public Health	Head of Public Health Programmes and Projects	R4	4.1a) Risk management should follow a PTHB standard framework and include seeking expert advice when necessary. For example, consulting with the SES before hiring premises. 4.1b) The register should have an owner and periodic review date. 4.1c)The register should be included in the reporting cycle at the appropriate level.	In response to the recommendations in 4.1a the Vaccination Service will check with the Health & Safety team whether a Licence Agreement needs to be in place for short term venues e.g. for 5 days. Winter Respiratory Vaccination Programme Final Internal Audit Report Appendix A NHSSP Audit and Assurance Services 16 • The Vaccination service needs to be agile and respond quickly to offer vaccination to protect the public from infectious diseases. Requesting other busy departments such as the Estates Team to source non-Healthcare venues could slow down processes particularity when short window for vaccinations. **Action**: Raise with the Health & Safety team and determine the correct processes to follow for Risk Assessment and	jun-24		Complete		Complete	This was discussed at the HB Health & Safety meeting of 17 June 2024 and their advice is that Vaccination Service does not need a Licence Agreement to be in place for short term venues. Next steps for Vaccination Service is to review short term venue hire checklist and ensure that venues being hired supply their appropriate risk assessments to HB (e.g. fire risk assessment). **19-08-2024** - Advice received from Health & Safety team and Vaccination service and incorporated in to our protocols. **18/12/2024** - Completed	NA	Risk Assessments have been done for every community setting visited.	July ODG	Yes, Health & Safety Group Minutes of 17 June 2024.			mar-25	jun-24	Yes, ready for closure
242501	Winter Respiratory Vaccination Programme	Substantial	Executive Director of Public Health		R5	5.1a) Data should be accessed to track and plan progress against the stated aim for increased dual vaccination. 5.1b) Regular updates should be included in the reporting hierarchy.	Note: • The vaccination programme in PTHB can only offer co-administration of COVID and flu vaccination to PTHB staff. All other flu vaccinations are administered in primary care and are recorded on primary care systems which the Health Board is not able to access. Winter Respiratory Vaccination Programme Final Internal Audit Report Appendix A NHSSP Audit and Assurance Services 18 • Anecdotal qualitative feedback from primary care providers has been that patients do not want both vaccines together- this is mirrored in the feedback we have received from staff attending the vaccination centres for their winter respiratory vaccines. • We can ask the information team to provide this data for us on any co-administration which takes place in our	sep-24		Complete		Complete	Until the final JCVI recommendations are issued it is challenging to plan for dual vaccination. Once the recommendations are issued dual vaccination can be included in the plan if operationally possible. **19-08-2024** - WRVP WHC was published 02 August 2024. The WHC states that 'Co-admin of Covid-19 and the flu vaccines should occur where effective and efficient to do so'. Our only opportunity to co-administer Covid-19 and flu is when GP participates in the Covid-19 programme or when delivering staff flu (although Health and Social Care staff are not a priority group for Covid-19 this year). Six GP practices have expressed an interest to vaccinate Covid-19. The same issues with Data systems and surveillance of co-administration are ongoing **18/12/2024** - where possible, co-administration has been offered. For example, during clinics for the PN group. GP practices participating in delivering Covid-19 have been encouraged to co-administer. National Data systems are not set up to report on number of co-administrations	Delay in JCVI statement. Issues with DHCW data	Regular communciation with VPW on potential announcement of JCVI and current planning assumptions.	Final sign off at PVG in early Sept	Yes			mar-25	jun-24	
242504	Follow Up Welsh Language Standards	Reasonable	Director of People and Culture	Service Improvement Manager Welsh Language & Equalities	R1	The Welsh Language Department should remind all Welsh Language Standards Service Leads of their responsibility to attend the WLS Group meetings. If they are unable to attend, then they should ensure that an appropriate member of the department attends instead. The Terms of Reference of the WLS Group should be updated to reflect the change in Executive Director responsibility for Welsh Language and then formally approved by the Group. The Welsh Language Department should issue a reminder to those Services that are yet to submit an updated Welsh Language Standards action plan of the requirement to do so with a suggested deadline. The Welsh Language Department should also consider enhancing the information recorded on the 'Action Plan' Log to note when updated Service Action Plans are received or if they are advised that there are no changes. Management may also consider reviewing this action plan at the WLS Group meetings. The Welsh Language Department should also consider scheduling individual meetings with the Welsh Language Service Leads prior to the WLS Group meetings. The meetings would allow an opportunity for the Service Leads to update the Welsh Language Department on any issues regarding the Welsh Language Standards for their Medium Follow-up: Welsh Language Standards Final Internal Audit Report Appendix A NHSSP Audit and Assurance Services 7 service and also allow for the review of the actual action plan. It is	he Welsh Language department will remind Welsh Language service leads that it is their responsibility to attend WLS Group meetings, and to submit an appropriate action plan. September 2024 Service Lead for Welsh Language 2 The Welsh Language Service Lead and Director of Workforce & OD have reviewed the ToR for the WLS Group meetings. Completed Service Lead for Welsh Language / Director of Workforce & Culture 3 The Welsh Language department have simplified the monitoring processes and will maintain the new documents centrally. This will include a place to note how recently an update has been received, or a notice that no update is required. Ongoing Service Lead for Welsh Language 4 All WLS Group members will be reminded of their ability to arrange 1:1 meetings as required; these will be scheduled where there is a need for enhanced scrutiny e.g. during a Welsh Language Commissioner's Investigation.	sep-24		Complete		Complete	**Dec-24** Departments were reminded of the requirements during the October 2024 meeting of the WL Service Leads group, and it is a standing item to remind participatns to update attendance and. Welsh language issues are now a regular item on many departmental team agendas.							mar-25	jun-24	
242504	Follow Up Welsh Language Standards	Reasonable	Director of People and Culture	Service Improvement Manager Welsh Language & Equalities	R2	All Welsh Language Service Leads should be reminded to ensure that Welsh Language Standards Compliance to be included as an agenda item at an appropriate management meeting. Re attendance at WLS Group, please see recommendation 1 above. Management should consider implementing version control for each occasion that the	1 Prior to the WLS Service Leads Group meeting in March members were reminded to ensure that Standards compliance should be a standing agenda item; some departments have responded to confirm that this is the case. Completed Service Lead for Welsh Language 2 See above. See Above Service Lead for Welsh Language 3			Complete		Complete	**Dec 24** Version control implemented. Participants in WL Service Leads group now sent regular reminders of need to keep membership p to date and ensure attendance.							mar-25	jun-24	
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Executive Director of Allied Health Professions, Health Sciences and Digital/Director of Corporate Governance / Associate Director of Estates, Facilities and Support Services/Head	R1	1.1) The THB should review current assignment of decarbonisation responsibilities, and capacity to deliver the same. 1.2) The decarbonisation governance structure, including key roles, forums and reporting lines, should be documented in an organogram. 1.3) ESG attendance should be promoted to ensure directorates and sub-groups are appropriately represented wherever possible. 1.4) Sub-groups should ensure that exception reports are submitted to ESG where necessary e.g. when there is a risk to delivery of their assigned actions from the DAP	The recommendation is agreed, and decarb responsibilities will be clarified under the current restructure with resource levels remaining unchanged. August 2024 Associate Director of Capital, Estates & Property 1.2 The recommendation is agreed, an organogram will be produced in line with the structure and reporting lines illustrated. August 2024 Head of Technical Services Decarbonisation Final Internal Audit Report Appendix A NHSSP Audit and Assurance Services 16 1.3 The recommendation is noted. Attendance at Environment and Sustainability Group will continue to be monitored, with the ambition to continue to widen and strengthen meeting membership across the organisation post reorganisation. September 2024 Head of Technical Services 1.4 The recommendation is agreed. Consistent implementation of exception reporting from the key subgroups will be applied	aug-24		Complete		Complete	Items 1.1, 1.2, 1.3 & 1.4 have been implemented and closed out.							mar-25	jun-24	
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R4	The DAP should incorporate known and estimated costs, where relevant	The recommendation is agreed. PTHB will utilise estimated costs from the recent Six Facet Survey in addition to the High Level Assessment undertaken by Re:fit to add costs to the Decarbonisation Action Plan. This work will help inform	nov-24		Complete		Complete	Estimated cost plans added to Decarbonisation Dashboard.							mar-25	jun-24	
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R5	The quarterly DCR returns should be retrospectively shared at an appropriate forum, e.g. IEG, recognising the timeframe does not allow for sharing and approval before submission. 5.2 At the DCR quarterly returns, actions should be RAG rated as required by the DCR team. 5.3 The THB should liaise with NHSSP to ascertain the current timeline for delivery of "Approach to Healthcare" actions 44.2 and 45.2	The recommendation is agreed. The latest DCR return was retrospectively shared with the April 2024 Innovative Environments Group and will continue to be shared at future meetings. n/a Actioned since audit fieldwork 5.2 The recommendation is noted. The Health Board has consistently used the same reporting approach during the submissions, which have been accepted by the DCR team. The Health Board will work with DCR team to review guidance in respect to 'past deadline' initiatives. However, in line with DCR guidelines, deadlines are financial year targets and none were past their respective deadline during last DCR submission (2023 Q4). August 2024 Head of Technical Services Decarbonisation Final Internal Audit Report Appendix A NHSSP Audit and Assurance Services 23 5.3 The Health Board will liaise with NHSSP for timeline for delivery of Approach to Healthcare actions 44.2 and 45.3.	aug-24		Complete		Complete	Actions complete - closed							mar-25	jun-24	
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services	R6	Further data analysis should be performed on the carbon reductions achieved to date against the baseline year, and on the future reductions forecast, to better understand the specific areas in which these savings will be achieved, and whether these are sustainable year on year. This information should be factored into the assurance provided to IEG/Board.	Carbon reduction data is reliant on a number of factors and is taken from a number of sources. The data sets continue to improve as understanding of the complex elements contributing to the calculations are better understood. One of the contradictory influences arises from capital investment in project activity, for example, Machynlleth hospital gave rise to a 'spike' in the reported carbon data for the period in which construction took place, whilst the project itself will deliver decarbonisation benefits for many years to come (solar photovoltaic, electric vehicle charging, insulation upgrade, triple glazing, etc.). Procurement data contributes over 60% of the carbon impacts for the organisation and the data has changed and evolved significantly over recent years. NHSSP-Procurement are making changes to their reporting which will take account of scope 3 indirect supply chain reporting and will continue to evolve. The Health Board decarbonisation roadmap is heavily reliant on delivery from Re:fit programme, whose Investment Grade Proposal is offering guaranteed 12.4% sustained carbon reductions. The step change in emissions will enable progress towards the 2030 net zero emission reduction targets	nov-24		Complete		Complete	Full assessment completing as part of Measurement & Verification (M&V) phase of ongoing Re:Fit programme which will be used to reassess the PTHB decarbonisation position following this substantial and positive change. Data analysis completed against Baseline for annual quantitative carbon emission reporting returns and provides pockets of data to support the investment into decarbonisation improvements and ensure sustainable growth in efficiency intervention and biodiversity enhancements. All of which can provide assurance to the Executive Team anbd Board of the strategy, approach and plans are providing sustainable solutions to the Climate Emergency and aligns with legislative goals from Environment Act, WBFG Act and Welsh Government Net Zero ambitions.							mar-25	jun-24	
242505	Decarbonisation	Reasonable	Director of Finance, Capital and Support Services	Head of Technical Services/Head of Capital	R7	Post-project reviews should be undertaken, where feasible, on completed decarbonisation-related projects, to assess whether the forecast benefits have been achieved. Lessons learnt should be shared to inform future investment decisions in decarbonisation.	The recommendation is noted, and the Health Board will look to expand the inclusion of decarbonisation benefits realisation within all major capital projects. It is expectation that funding from Welsh Government is evaluated against decarbonisation targets and so this recommendation will close the loop on evaluating delivery against	Q4 2024		Complete		Complete	Recommendation has been included in extant major decarbonisation programmes, including Bronllys roof project and will be added within lessons learned process going forward. Continued support through Welsh Government funding programmes provides objective review of data and outcomes from the Health Board.							mar-25	jun-24	
242508	Risk Management and Assurance	Reasonable	Medical Director	Chief Pharmacist	R3	Formal Processes should be established within the Medicines Management department, and Medical Directors Office to ensure regular review and formal reporting of their respective risk registers, and their collegiate risk issues as a whole. This would also provide an assurance mechanism that those high scoring risks that can't be managed at departmental and Directorate levels can be discussed, and then escalated if	Medicines Management/Pharmacy service leads to ensure that all Medicines Management/Pharmacy risks are reviewed on a monthly basis and that the risk register is updated as appropriate, initialled and dated. Risk register to be a quarterly standing agenda item on the senior pharmacist meeting agenda. Formal quarterly meeting between Medical Director and Chief Pharmacist in place to go through Medicines Management/Pharmacy Risk Register to ensure that a risks	Ongoing		Complete		Complete	Medicines Management/Pharmacy service leads (Head of Primary Care Medicines Management, Head of Community Services Medicines Management, Senior Pharmacist Formulary Management and High-cost drugs, and Senior Pharmacist Digital and Patient Safety) requested by Chief Pharmacist to review and update the risk register on a monthly basis. Initials to be added against review dates. Monthly meetings in place between the Chief Pharmacist and Medical Director to review Medicines Management/Pharmacy Risk Register. Risks scoring ≥ 12 escalated to the Risk and Assurance Group							mar-25	jul-24	

242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service	R5	Management should ensure that Operational staff are reminded that Cleaning Schedules must always be fully completed.	Maintain quality assurance reports around audit compliance at the Support Services Quality Assurance Meeting.	01.04.2025		Complete		Complete	We are already operating this process. Operational staff are regularly reminded to ensure that Cleaning Schedules are fully completed, and quality assurance reports regarding audit compliance are consistently maintained and reviewed at the Support Services Quality Assurance Meeting.							mar-25	12.11.2024	
242514	Staff Retention Final Internal Audit Report	Reasonable	Director of People and Culture	Julia Williams, Workforce Retention	R1	Management should ensure they include target dates for the actions of the National Nurse Retention Plan, so Health Board expectations and priorities to be reported to HEIW are known and prioritised.	Target dates to be agreed against each of the actions by the task and finish groups, with continual progress monitored and reported into Steering Group.	31.01.2025		Complete		Complete	**Feb 25** Every action has now been assigned a target completion date and progress is reported to Workforce Retention Steering Group.							mar-25	10.02.2025	
242515	Capital Systems Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital	Head of Capital	R1	Expected Evidence of Implementation: • Capital Procedures updated and signed off at Innovative Environments Group 8 November 2024 • Reference booklet CP4.3 Capital Strategy	A 'contract strategy' form to be added to the Capital Procedures booklet to capture decisions and justification for chosen form of contract for each applicable project. The updated capital	31/11/2024		Complete		Complete								mar-25	10.02.2025	
242515	Capital Systems Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital	Associate Director Capital, Estates and Facilities	R3	Expected Evidence of Implementation: • Action Tracker developed which will be a fixed agenda item for the Estates / NWSSP Procurement meetings	The 2023/24 Procurement Annual Report was received on 8 November 2024. An Action Plan will be created based on Areas for Improvement recommendations and this will be reviewed with NWSSP-Procurement Services during routine Procurement	31/11/2024		Complete		Complete								mar-25	10.02.2025	
242515	Capital Systems Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital Estates	Head of Capital	R4	Expected Evidence of Implementation: • Capital Procedures updated and signed off at Innovative Environments Group 8 November 2024 • Section 5.4 Completion Requirements reflects the updated guidance on document retention period	Capital Procedures will be updated to reflect a recommendation to retain the Project File for the lifetime of the building as part of the Health & Safety File CDM requirement. It was not considered viable or economic in terms of resource to periodically (6 years,	31/11/2024		Complete		Complete	Sign off completed with IEG. 'Section 5.4' recommendation is noted for guidance but extant process to maintain recrods for life of buildings will be maintained for current and furture safe management and maintenance purposes.							mar-25	10.02.2025	
242516	Energy Management Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital Estates	Environmental and Sustainability Manager.	R1	Expected Evidence of Implementation: • Agenda and minutes of Utilities Management Group.	Management Action: Welsh Energy Operational Group meeting update is now a standard agenda item at the Utilities Management Group. Issues will be escalated by exception to the Environment and Sustainability Group/Innovative Environments Group, as	31/11/2024		Complete		Complete	Issues are escalated by exception to the utilities management group and ESG							mar-25	10.02.2025	
242516	Energy Management Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital	Finance Business Partner	R2	Expected Evidence of Implementation: • Finance attendance at WEG meeting week commencing 18 November 2024.	Management Action: PTHB Environment and Sustainability represent the organisation at the Wales Energy Operational Group. Finance will provide representation at Welsh Energy Group (WEG) meetings where	31/11/2024		Complete		Complete	Finance now attends WEG group meeting							mar-25	10.02.2025	
242516	Energy Management Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital Estates	Environmental and Sustainability Manager.	R3	Expected Evidence of Implementation: • Audit Plan with energy audits commencing November 2024 Medium Priority Officer: Environmental and Sustainability Manager. Theme: Financial Management & Control Control Operation	Management Action: 'Site walkaround' energy audits will be included in the ISO 14001 annual audit schedule. The audits will be conducted by the Environment and Sustainability team with outcomes reported	31/11/2024		Complete		Complete	All hospital and larger clinics undertaken							mar-25	10.02.2025	
242516	Energy Management Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital Estates	Environmental and Sustainability Manager.	R4	Expected Evidence of Implementation: • Agenda and minutes of Utilities Management Group.	Management Action: Feedback and identification of risks and issues from Welsh Energy Operational Group and Welsh Energy Group will be reported via the agenda item at the PTHB Utilities Management Group and escalated by exception to the Environment and Sustainability Group/Innovative Environments Group, as	31/11/2024		Complete		Complete	Issues are escalated by exception to the utilities management group and ESG							mar-25	10.02.2025	

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	Ready for Closure Yes/No	Justification for Closure	Update received
														Progress of work underway	Barriers to implementation including any	How is the risk identified being mitigated pending	When will implementation be achieved?								
242509	End of Life Care Services Final Internal Audit Report	Reasonable	Medical Director	Louise Hymer, Macmillan Lead Nurse for Cancer and Palliative Care	R1	Management should undertake a review of the current service needs and provision for end of life services as soon as possilbe. A review of the pilot being undertaken with the North Locality should also be undertaken with a view to implementing across all localities. Whilst the focus of the audit has been on the IN-House service provision, due to the concerns raised by staff it is recommended that the provision of OUt of Hours Service is also reviews	**In Hours** - We will work on reporting process to understand service activity, demand and capacity, and then work to review the establishment of the Specialist Pallative capacity, and then work to review the establishment of the Specialist Palliative Care Team, as part of sustainability planning within the Health Board. **Review of pilot - triage nurse** The Specialist Palliative Care Tean will continue to review the piloto of a triage nurse curreently being undertaken in North Powys, and share the learning with the Mid and South localities, identifying how this model could support service delivery - N.B. the establishemnt of staff in the Mid and South is currently lower, therefore the model may not be effectively embedded in these areas until the wider team establishment is reviewed, the option of a Pan-Powys triage approach will be explored. **Out of Hours** Provision of commisseoned services provided via hospice partners across Walles is currently being reviewed by the Joint Commissioning Committee, this process commenced in April 2024; with all hhealth boards across Wales being asked to pause any new hospice commissioning agreements Prior to this change, PTHB was in the process of reviewing the hospice commissioned services to ensure they were fit for purpose and met the needs of our palliative and end of life patients. We are anticipating regular updates from the JCC, and fully partiipate in the review process, if required we will build on the JCC work to ensure the needs	mar-25		Not yet due		On track		17/12/2024 - activity audit of the Specialist Palliative Care Team Nurses was undertaken in November, data from this is currenlty being analysed and will be reported shortly, activity data from CANiSC (PAS system for Specialist Palliative Care) is also being reviewed to inform ongoing review of the establishment of the team. The line management of the service is currently under review, once this is confirmed reporting mechanisms will be identified. Currently awaiting an update on the progress of the JCC review of hospice commissioning to inform ongoing plans re review of commissioned services. Plan to work with St Michael's Hospice in Q4 to undertake 'deep dive' of PTHB activity.							mar-25	12.11.2024			
242510	Integrated Plan Development Process Final Internal Audit Report	Reasonable	Executive Director of People and Culture/Executive Director of Improvement and		R1	Management need to develop a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Health Board's plan is not in balance. (Board SFI 5C.C)	Agreed. The Health Board is developing a Routemap to Sustainability, which is intended to fulfil this requirement. It is anticipated that the proposals it contains will need to be subject to Engagement, and then Consultation, with the public, staff and other stakeholders. Develop proposals for a sustainable recovery plan.	mar-25		Not yet due		On track									mar-25	12.11.2024			
242510	Integrated Plan Development Process Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services		R2	Management should ensure that future plans identify robust schemes to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.	Agreed. Each year, the Health Board strives to identify and develop a full set of robust schemes to support the delivery of the savings target within the Financial Plan. This is a collective activity, led by the Executive Director of Finance, Capital and Support Services, which all the Executive team	mar-25		Not yet due		On track									mar-25	12.11.2024			
242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service Improvement Manager	R1	A review of governance and reporting arrangements in relation to Support Services and cleaning standards should be undertaken to ensure there is a clear line of reporting and escalation upto Board level. The revised reporting arrangements should then be formally approved at the appropriate Board/Committee meeting. Upon completion of the review, the TOR documents of any relevant committees should be updated to reflect the	**1.1** Review the reporting arrangements from the Directorate to the Board level for Cleaning Standards. **1.2** Update the TOR for the respective groups to ensure they reflect the need to receive and report on cleaning standards.	01.04.2025		Not yet due		Partially complete		A review of governance and reporting arrangements for cleaning standards is currently under consideration, with the most likely outcome, given the critical importance of IPC, being its alignment under the Nursing Directorate. Additionally, it is anticipated that an Environmental Cleanliness Group will be reinstated, with a comprehensive review and development of its Terms of Reference to follow.							mar-25	12.11.2024			
242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service	R3	Management should ensure that any areas/services within the Health Board where cleaning services are provided by an external body that mechanisms are implemented to provide assurance of compliance with the Health Board's cleaning standards.	Support Services to support the quality monitoring of the renal contract for the hospital.	01.04.2025		Not yet due		Partially complete		We are committed to ensuring robust assurance mechanisms for cleaning standards across all areas within PTHB. While audits are carried out by the management of third-party cleaning providers, it would be prudent for us to arrange to receive evidence of these audits and conduct our own managerial audits periodically to provide additional assurance. To strengthen oversight, PTHB cleaning audits will be extended to include areas cleaned by third-party providers operating within PTHB properties where appropriate, ensuring they meet the required standards. Additionally, we will implement appropriate mechanisms to monitor and verify compliance, reinforcing our commitment to maintaining high levels of cleanliness and infection							mar-25	12.11.2024			
242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service	R4	Management should consider collating local training records to produce a central training record. This should be periodically reviewed to ensure compliance rates are maintained at a satisfactory level, and to enable any anomalies to be identified and addressed at the earliest opportunity.	A sharepoint folder system to be established which is managed centrally and accessible by local managers to upload training compliance records.	01.04.2025		Not yet due		Partially complete		We are currently establishing the electronic centralising local training records, which will improve record-keeping and provide better oversight of training compliance.							mar-25	12.11.2024			
242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service	R6	Management should review all information that is currently recorded and available in respect of Cleaning Standards. Discussions should then take place as to what Committee this information should be reported to and the frequency of the updates.	1. Create a reporting dashboard which brings together what is currently recorded and available in respect to cleaning standards. 2. Confirm which Management Meeting and Executive Committee this dashboard is reported to.	01.04.2025		Not yet due		Partially complete		We currently track and report on cleaning standards via a dashboard, with reporting restricted currently to the IPC Committee, the Facilities Management Teams and assigned stakeholders on their specific request. Once the new Cleaning Standards Group is established, this will be realigned. Management will review the existing data, decide the appropriate committee for reporting, and establish the reporting frequency. The dashboard will consolidate the information, and we will confirm the relevant management and executive committees for reporting.							mar-25	12.11.2024			
242512	Core Financial Systems - Treasury Management Final Internal Audit Report	Substantial	Director of Finance (Accounting and Services)	Sarah Pritchard, Assistant Director of Finance (Accounting	R3	Efforts should continue to ensure all FCPs with elapsed review dates are subject to an appropriate review process and submitted for the relevant approvals. Future review dates should then be defined, or an established review frequency should be determined and specified within each document.	Agreed - There is currently LHB review of policy process underway which is due to conclude during 24/25. All FCPs will be reviewed and where required approval undertaken and where required review frequency included within the document.	31.03.2025		Not yet due		On track									mar-25	10.02.2025			
242512	Core Financial Systems - Treasury Management Final Internal	Substantial	Director of Finance (Accounting and Services)	Ian Jackson, Financial Accountant	R4	Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.	Agreed - The finance department are reliant on local administration teams advising of changes required. A full review will be undertaken and signatories updated to reflect current signatories only where required	31.03.2025		Not yet due		On track									mar-25	10.02.2025			
242512	Core Financial Systems - Treasury Management Final Internal Audit Report	Substantial	Director of Finance (Accounting and Services)	Ian Jackson, Financial Accountant	R5	Financial limits should be implemented in respect of all authorised signatories of subsidiary bank accounts. In cases where higher limits are determined to be necessary, consideration should be given to adding a stipulation requiring two signatories to authorise payments which exceed a predefined threshold.	Agreed - Officers will work with the bank to ensure the documentation is updated for all accounts to define a limit where this is currently omitted.	31.03.2025		Not yet due		On track									mar-25	10.02.2025			
242512	Core Financial Systems - Treasury Management Final Internal	Substantial	Director of Finance (Accounting and Services)	Ian Jackson, Financial Accountant	R6	A list of authorised signatories should be maintained and subject to periodic review.	Agreed - A list of mandate signatories will be defined and subject+H61:H62 to regular review	31.03.2025		Not yet due		On track									mar-25	10.02.2025			
242513	Records Management Final Audit Report	Substantial	Director of Finance (Accounting and Services)	Wayne Tannahill, Associate Director of Capital,	R1	Although fire detection is in place, there is no fire suppression in records storage areas.	The Health Board will consider the feasibility of introducing fire suppression within record storage areas	31.03.2025		Not yet due		On track		Feasibility to retro fit fire suppression systems to record store is bering undertaken for informed evaluation of corrective action against outcomes.							mar-25	10.02.2025			
242514	Staff Retention Final Internal Audit Report	Reasonable	Director of People and Culture	Julia Williams, Workforce Retention Lead	R2	Management should ensure that the local Workforce Retention Plan is fully developed as soon as possible with the allocation of target dates for the completion of actions and is then made available for use for by the Health Board. The initiatives that have been developed following the analysis undertaken by the Health Board's Retention lead should be incorporated into the Plan to ensure that they are effectively implemented.	Develop the Workforce Retention Improvement Plan for Powys Teaching Health Board and gain Executive sign off prior to implementation.	31.03.2025		Not yet due		On track		**Feb 25** Workforce Retention Imporcement Plan is in draft and awaiting review by senior colleagues in People and Culture. It will be shared with the Workforce Retention steering group before Executive sign off.							mar-25	10.02.2025			
242514	Staff Retention Final Internal Audit Report	Reasonable	Director of People and Culture	Julia Williams, Workforce Retention Lead	R3	Management should ensure that the current plans are fully implemented, and then explore any further ways of improving the completion rate of exit questionnaires, ensuring adequate staff communication is put in place. There should also be a system in place to formally include the relevance and need to complete exit questionnaires at local management training and corporate induction programmes. The exit questionnaire process guidance should be finalised for use by the Health Board.	Complete development of manager and employee information around exit questionnaires and communicate this with all staff through a multi-modal communication plan Complete quality improvement project to improve exit questionnaire completion rate for Registered Nurse's with the Community Services Group and replicate successes across the organisation. Ensure exit questionnaire relevance and importance is included in programme of education within the PTHB	January 2025 March 2025 December 2025 January 2025		Not yet due		On track		**Feb 25** Following discussion with senior leadership team in People and Culture, a review of the exit questionnaire process has taken place. The process achieves low completion rate and the data available from the process does not provide robust information to allow for changes to be implemented. It also only captures staff leaving the orgnaisation rather than those moving internally too. Therefore, the decision has been made to chnage the current process and develop a leavers toolkit which not only provides information to staff and managers, it includes a template leavers questionnaire for managers to complete with departing staff members, and an online questionnaire for leaving staff members to complete independently. Development is well underway and once complete we will implement a communication plan, and ensure information is provided in the PTHB managers programme and corproate induction.							mar-25	10.02.2025		**NOTE: Multiple actions with different completion dates within the same recommendation**	
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and	Jayne Wheeler Sexton	R2	Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.	A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of	March 2025 July 2025 September 2025		Not yet due		On track		20/02/25 -Business case made to IBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. Information requested from ESR to start analysis of training needs around MCA. The next MCA operational and Practice Improvement Group in March 25 has an agenda							mar-25	10.02.2025		**NOTE: Multiple actions with different completion dates within the same recommendation**	
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and	Jayne Wheeler Sexton	R3	The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement	28.02.2025		Not yet due		On track		20/2/25 - Action First who have this contract have provided Safegaurding Team with required docuentation that is held and monitored by the Business manager. In liasion with procurement agreed that provider will ensure we are advised and updated with the relevant documents of any new assessor that provides assessments to PTHB. Completed.							mar-25	10.02.2025			
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family	Jayne Wheeler Sexton	R4	The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be	March 2025 June 2025		Not yet due		On track		20/02/25 -Business case made to IBG. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information.							mar-25	10.02.2025		**NOTE: Multiple actions with different completion dates within the same recommendation**	

242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	HS	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	A business case will need to be made for the role of DoLS co-ordinator. This role will include to sign off the applications and review the current	March 2025 June 2025		Not yet due		On track		20/02/25 -Business case made to IBC. Agreement received to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. Information requested from ESR to start analysis of training needs around MCA. The next MCA operational and Practice Improvement Group in March 25 has an agenda							mar-25	10.02.2025	NOTE: Multiple actions with different completion dates within the same recommendation
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	HS	Management reports should be developed to record ongoing performance against the target dates. These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required. The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether or not the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data.	The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A DoLs Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group.	March 2025 June 2025 June 2025		Not yet due		On track		20/02/25 -Business case made to IBC. Agreement to proceed to exec committee following some additions. Meeting with business partner and author on the 24.1.25 to complete required additional information. The case tracker spreadsheet has been developed and commenced from the 17/2/25. Updated data reporting will commence from April 25.							mar-25	10.02.2025	NOTE: Multiple actions with different completion dates within the same recommendation

Internal Audit Recommendations Overdue

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justifica	PTHB Ref. No.				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	For Closure Yes/No	Justification for Closure	Update received
														Progress of work underway	Barriers to implementation including any	How is the risk identified being mitigated pending	When will implementation be achieved?								
192022	Outpatients Planned Activity	Reasonable	Director of Primary Care		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access Policy within the health board will be developed that details roles and responsibilities and sets out the general principles and rules for managing patients through their elective care pathway. WG are currently reviewing national waiting times standards (RTT) in light of COVID19 19 and the impact of new ways of working e.g. digital appointment solutions like Attend Anywhere. The Patient Access Policy will be	mar-21	mar-22	Overdue		Partially complete		This work has been delayed due to covid but also now needs to be considered in line with national guidance on pathways and the Powys renewal priorities. This will take until end of the year. This work is now further delayed due to the required Health Board adoption of Care Pathways. A revised policy document will aim to be completed by Nov 24 **February 2025** - Reassigned to Primary Care (Originally assigned to Planning and Commissioning)- QSEG has been stood down and the new management system is in place. Delay decison-making around further reporting due to Executive Director of Nursing availability.	Waiting for overall WG rollout. See earlier comment	Adopt treat in turn methodology and adherence to extant all Wales access policy	jun-23		47	35	mar-25	sep-20	NO	PTHB needs an over-arching Access Policy so the action needs to stay open. Aim for a draft policy to be written by March 24.	
212207	Dementia Services- Home Treatment Teams	Reasonable	Director of Improvement & Transformation		R1	The operating environment within both teams needs further evaluation, to ensure clients have consistent access to services throughout the Health Board and good practice can be shared and embedded.	The configuration of the North Powys team to match the clinical specialism of the South will require additional funding, as well as any move to the South Team matching the North's 7- Day working practices. Elements of this funding will be considered as part of the Mental Health Service Improvement funding and any additional funding released by Welsh Government.	sep-22		Overdue	Low	Partially complete		There is still no funding to enable the expansion of the team to accommodate 7 day working. This will be considered within the overall MH model of care through the MH Transformation work now known as 'Better Together'. Some delays in progress have occurred as a result of the need to reprioritise the implementation of 111 press 2 in line with Welsh Government timescales. This service went live in 2023 but the ASM programme requires appointment of a Transformation Programme Manager, recruitment of which is underway. The eventual model will be incorporated into our OBC	Additional financial resources and reconfiguration of older adult services are required in order to operate the service on 7 day basis.	Should patients deteriorate over weekend, inpatient and MHA processes are available.	7 day working for the DHTT will be considered as part of the Mental Health transformation work. Completion date will exceed the agreed deadline for this action.	jun-23	30	1502	mar-25	jan-22	18.12.2024 - No update		
212207	Dementia Services- Home Treatment Teams	Reasonable	Director of Improvement & Transformation		R2	The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee. Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the operational updating of the WCCIS System.	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 - day basis we will require two flow charts demonstration patient flow and the method of referral. The SOP requires finalisation and until full expansion of the service will require two sections, relating to North and South Powys. This will include an update on WCCIS forms to be utilised, however, it should be noted that this work is conducted on an all-Wales basis and all agencies using WCCIS are required to agree to the same forms and	apr-22		Overdue		Partially complete		Strong progress has been made on the SOP, and updating WCCIS forms is underway. However, these need to be agreed at a national level before they are implemented. Authorisation still awaited. Update: the SOP is complete but the Policy in place will need to be updated again in line with the outcomes of work through the Better Together ASM programme to reflect consistency for a Pan Powys model	Need for Policy to reflect a Pan Powys approach rather than having sub SOPs for the two pathways of North and South. This action should therefore remain in the aidt recs tracker until complete.			jun-23	35	1502	mar-25	jan-22	18.12.2024 - No update		
232401	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	David Farnsworth/Chris Moss	R1	Procedural documentation should be developed which sets out in detail how actions regarding In-reach Medical Staff should be undertaken by the Health Board's staff.	Develop Standard Operating Procedure setting out in detail how actions regarding in-reach medical staff should be undertaken. This will include an information pack of PTHB policies and procedures for visiting consultants. Develop process/procedure for development of a Service Level Agreement.	nov-23		Overdue		Partially complete		SOPs in process of being revised, but behind original deadline. SLAs in process of being revised and updated by the Head of Commissioning and to be presented to the Executive Team for approval. **20/3/2024** - SLA template updated for 2024/25 and to be presented along with updated LTA template to Executive Team. **16/12/2024** - SLA template update not completed for 24/25. Planned Care and Commissioning teams to continue to develop with view to implement for 2025/26.					16	1502	mar-25				
232403	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and	Katie Games	R3	SLAs should be signed off with all providers of In-reach Medical Staff on a timely basis.	To ensure that all agreements signed within financial year. Aim to have timelier sign off of agreements with NHSE providers.	sep-23		Overdue		Partially complete		**16/12/24** All SLAs with Welsh providers have been signed for 24/25. Work ongoing to sign the 24/25 SLAs with English providers.					13	1500	mar-25				
232404	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and	Katie Games	R4	The frequency of meetings should be reviewed to determine what is appropriate to reflect the level of risk for each provider of In-reach Medical Staff and this should then be reflected in the SLAs. Following this, Contract Quality Performance and Review Meetings should be held in line with the frequency	Regular SLA review meetings to be held independently to the CQPRM's. In 2024/25 further alignment of the SLAs to the Integrated Performance Framework.	sep-23		Overdue		Partially complete		We continue to include as an agenda item in the CQPRMs, once action 232402 has been completed we will look at holding separate meetings. Please note, the only exception is Wye Valley, we have service to service meetings set up from Nov to discuss performance etc. **09/09/2024** - SLA meetings to be further refined to reflect updated Integrated Quality and Performance Framework. **16/12/2024** - new Head of Commissioning in place, to undertake review of the CQPRM process.					13	1500	mar-25				
232405	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R5	Performance and quality monitoring against the SLA should clearly identify and consider: • The number of sessions expected and provided by each clinician. • Where the number of sessions provided is below the number expected, how the provider Health body proposes to rectify the deficit. • The cost per session expected and charged for each clinician. • Where the cost per session charged is higher than the cost	Internal review ongoing re the SLA activity delivered YTD compared to commissioned baseline and how this feeds into invoice validation. This aims to ensure robust oversight of SLA sessions delivered against expected activity (and any mitigating actions to address under performance), robustly costed and agreed financial schedules.	des-23		Overdue		Partially complete		**16/12/24** - This is linked to action 232402 and 232404					13	1500	mar-25				
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Head of Quality and Safety	R1	The Incident Management framework should be reviewed and updated so that it includes the incident management governance arrangements, specifically demonstrating the clear lines of reporting across all parts of the organisation, including through to the relevant Committees of the Board.	Update the Incident Management Framework to reflect the Health Board governance arrangements for the management of Nationally Reportable Incidents	feb-24		Overdue		No progress		**Dec 24** planned for competion in Q1 2025 subject to the launch of the Peoples Experience Framework **19/02/2025 - no further update at this stage**					11	0	mar-25	jan-24			
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R3	Senior management within Service Areas should ensure that: • Incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. A review is undertaken of the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. • The current reporting capabilities of the Datix system and the weekly monitoring efforts by	Services to provide an action plan for improvement to support how they intend to manage overdue incidents along with timely management of new incidents in line with the Incident Management Framework.	mar-24		Overdue		Partially complete		Weekly notifications sent to incident managers to manage incidents in compliance with IMF. Further reports provided to Executive Directors and Heads of service monthly to ensure opportunities to support timeline management. **19/02/2025 - no further update at this stage**		Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation			10	6	mar-25	jan-24			
232415	Incident Management	Reasonable	Director of Nursing, Quality, Women and Family Health	Executive Director of Nursing, Quality, Women and Family Health	R4	Management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence.	Services to review systems in place to monitor lessons learned to support appropriate triangulation and improvement	mai-24		Overdue		Partially complete		reported locally through the service group led quality and safety forums. This is then reported through the Professional Nursing and Midwifery Oversight Group on a monthly basis. Progress on NRI/EWN/DoC **19/02/2025 - no further update at this stage**					8	6	mar-25	jan-24			
242501	Winter Respiratory Vaccination Programme	Reasonable	Executive Director of Public Health	Head of Public Health Programmes and Projects	R2	2.1a) Communications with Schools should also extend to Governors, increasing the level of school oversight. 2.1b) PTHB expert data protection advice should be sought to help overcome objections. 2.1c) Controls procedures are agreed that ensure all communications reflect the most up to date information. 2.1d) The procedure has an owner, reviewer, appropriate review periods and is communicated to all participating parties.	2.1a & C) **Action**: Develop overarching communication strategy and action plan to cover all vaccinations 2.1b) Escalation has already commenced to address the issues currently experienced with accessing class lists and parent/carer contact details. Should there be a delay in the sign off of the ISP by the Local Authority, consideration will be given to communicating with school governors. **Action:** This is being actioned through the development of an ISP and is awaiting final sign off by the local authority Sept 2024 Ongoing Sarah Barnes, Head of Service: Public Health Programmes & Projects Wendy Day, Assistant Head of Public Health Nursing 2.1d) **Action:** Recent review of the Standard Operating Procedure has been completed and will next be due for review in January 2027. The procedure has an owner, reviewer, appropriate review periods and is communicated to all participating parties.	sep-24		Overdue		Partially complete		An overarching Local comms plan is being developed for all vaccinations and will incoporate the Winter Respiratory Vaccination Programme. A draft National Comms Plan is currently out for comment from VPDP who are leading on the National Comms. Actions from the National Comms Plan will be included in the Local Comms Plan. Further specific comms with schools will be devloped **19-08-2024** - no change to this action. Comms plans will be discussed at ODG 22 August and PVG in Sept. **18/12/2024** - Comms plans and actions for each individual vaccination project has been completed and is discussed and reviwed at the ODG as part of the Project Leads updates. Communications comprised utilising National resources, social media messages, information circulated to stakeholders, posters, printed media. Our initial action response was for an overarching comms plan for all vaccinations. As the work devloped over the last few months it was easier to incldue individual comms plans and actions as part of each vaccs camapign. It remains an ambition for the ODG group to develop one overarching strategy. The mapping of all campaigns and the national resources to support has been undertaken. **20/02/2025 -** Data sharing agreement developed with Information Governance and Women & Children's services. Agreement with Local Authority for final signoff.	More time required to develop the Comms Plan to incorporate all programmes 18/12/2024 - Signoff of data sharing agreement between School Health Service and PCC has yet to be agreed.	WRVP plans are discussed at the monthly HB Vaccination Operational Delivery Group. All members have been asked to develop their Action plans by end June. Any commimocations required and identified can be included in the Comms plan.	Each vaccs campaign that has been implmented since the Audit review has had its own comms actions and plan. The only outstanding action from this suite of recommendations is the sign off of the data sharing agreement with Child Health?School Health Nursing and PCC.	Yes			mar-25	jun-24			
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care	R6	Management should ensure that key information regarding continuing healthcare activity and quality and safety issues are included in Health Board reports for submission to the appropriate Health Board Committees	There is a highlight report produced and shared monthly that illustrates CHC activity and more. This is being reviewed and revised with a meeting scheduled with the Performance team on 22.05.24 to see how they can support this work and create a more inclusive reporting system.	31.01.25		Overdue		Partially complete		**Aug 24** - Although there has been work to progress this, the national position continues to be unsupportive of the health board data returns. No further progress to report **Dec 24 February 2025** The health board is still awaiting a national funding decision on an electronic system. In the meantime, work has commenced through a CHC workhop on 19.02.2025							mar-25	jul-24			
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care/Deputy Director of Nursing	R7	Management should consider reviewing the reporting arrangements of the QSEG to allow for regular update reports from the group to be submitted to the Health Board's PEQS Committee	Reporting to PEQS has been discussed at QSEG and it is agreed that there does need to be the reporting of quality themes/issues in place. The current committee structure is changing to implement an integrated reporting system where quality and performance can be included in a single report.	31.12.24		Overdue		Partially complete		**Aug 24** - Awaiting further discussion with new Exec DIrector regarding future reporting. In the meantime QSEG continues and the Complex Care Operational Management Group is in place with reporting to D & P Committee. No further progress to report **Dec 24 February 2025 see below comment**							mar-25	jul-24			
242507	Patient Experience (Final Report)	Reasonable	Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality and Safety	R1	The patient experience strategy should be formally reviewed to ensure that it adequately covers all required matters.	Recommendation accepted. Review PEP 007 'Powys Patient Experience Strategy 2016 – 2019' and consider updating in line with Welsh Government Framework and Quality & Engagement (Wales) Act 2020.	31.01.2025		Overdue		No progress		**Dec 24** Awaiting launch of Peoples Experiences Framwork. PTHB will use this framwork to develop its own framework **19/02/2025 - no further update at this stage**	Awaiting Launch of national framework						mar-25	jul-24			
242507	Patient Experience (Final Report)	Reasonable	Director of Nursing, Quality, Women and Family	Assistant Director of Quality and Safety	R2	Further work is required to identify how the low patient experience response rates can be improved and then roll out the lessons learnt to be applied consistently to all service areas.	Recommendation accepted. Continue to ensure response rates to CIVICA surveys are considered within service meetings, Patient Experience Group along with Patient Experience Quality & Safety Committee. With a continuous focus of improvement to address variation in the way feedback is	30.09.24		Overdue		No progress		**Dec 24 - t**here are opportunies for service areas to report progress at the Patient Experience Steering Group. **19/02/2025 - no further up date at this stage**					4		mar-25	jul-24			

242508	Risk Management and Assurance	Reasonable	Executive Director of Nursing, Quality, Women & Childrens	Assistant Director Women and Children	R4	All risks stated on the risk register should be reviewed in accordance with a prescribed review timescale that is commensurate to the level of risk scoring. Risks should also be supported by a brief narrative to state action to be undertaken to mitigate each risk, a proposed timescale for completion if practicable, and an action progress update provided during each review undertaken.	Risk registers will be reviewed and updated within the monthly Women & Children Quality & Performance meeting, to ensure timely updates and escalation as required	30.07.2024		Overdue		No progress		**Dec 24** Risks are reviewed and updated on a monthly basis, currently risks are being transfered to Datix module from XL spreadsheet. **10/02/2025 - no further update at this stage**					5		mar-25	Jul-24	
242509	End of Life Care Services Final Internal Audit Report	Reasonable	Medical Director	Louise Hymer, Macmillan Lead Nurse for Cancer and Palliative Care	R2	Management should ensure that these documents overdue for review are reviewed and approved by an appropriate forum as soon as possible. Once approved the updated documents need to be made accessible to all Health Board staff. For the remaining procedure (PTHB/GNP 075) management need to determine if reviews have taken place and ensure latest version of the document is available to all Health Board staff.	**PTHB/GNP 00**- Verification of Death by a Healthcare professional Policy. We will link with the accountable Executive (Executive Director of Nursing) to ensure the document is updated. **PTHB/GNP 081** - Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals. Link with the accountable Executive (Executive Director of Nursing) to ensure the document is updated. **PTHB /GNP 075** - Administration of as needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales (The CARAD Package). Continue to liaise with team in BCUHB who are currently updating the Policy- once available to progress through PTHB policy processes.	jan-25		Overdue		Partially complete		17/12/2024 - GNP 075 in process of being updated - awaiting agreement related to training for use of the devices, the Clinical Education Team will lead on the training, with training being provided to the Clinical Education Team by the manufacturer in January 2025, following this the policy will be updated to include the new training offer and be ready for ratification. Update awaited re GNP 001 and GNP 081.							mar-25	12.11.2024	
242509	End of Life Care Services Final Internal Audit Report	Reasonable	Medical Director	Louise Hymer, Macmillan Lead Nurse for Cancer and Palliative Care	R3	Management should review the data that is currently being collated by the Service in order to to consider which information should included as part of Health Board's Integrated Quality and Performance Report. We acknowledge that not all data collated can be includedwith the Health Board's Integrated Quality and Performance Report and so Management should also review and consider any additional information that should be reported within the Community Services Group.	W will review the reporting measures of the Specialist Palliative Care Team within the Community Services Group and identify an appropriate reporting mechanism, in line with the recommendations within this report. We will aso work with our commissioning team to ensure that systems related to to the reporting of commissioned palliative/ End of Life services are robust.	jan-25		Overdue		Partially complete		17/12/2024 - The line management / reporting structure of the service is currently under review, once this is confirmed reporting mechanisms will be identified. Currently awaiting an update on the progress of the JCC review of hospice commissioning to inform ongoing plans re review of commissioned services. Plan to work with St Michael's Hospice in Q4 to undertake 'deep dive' of PTHB activity.							mar-25	12.11.2024	
242511	Cleaning Standards Final Internal Audit Report	Reasonable	Executive Director of Finance, Capital and Support Services	Jason Crowl, Assistant Director - Support Services Duncan Crawley, Service	R2	Management should ensure that the Environmental Cleanliness Standards Operating Procedure and any other relevant documentation is reviewed and updated to reflect the current Executive arrangements.	Update the Environmental Cleanliness Standards Operating Procedure to reflect Current Executive arrangements.	01.04.2025		Overdue		Partially complete		**(due completion date incorrectly showing in the final report, should read 31/04/2026)** We acknowledge the importance of ensuring that documentation aligns with the latest agreed governance structures, as well as the forthcoming publication of the new NHS Wales Cleaning Standards. A full review and update of the Environmental Cleanliness Standards Operating Procedure will be undertaken to reflect the revised Executive arrangements once the new standards are published. In the interim, a desktop review will be conducted to ensure the procedure remains sufficient.The current edition of the procedure remains extant until June							mar-25	12.11.2024	
242512	Core Financial Systems - Treasury Management Final Internal	Substantial	Director of Corporate Governance		R1	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.	Agreed - The SFIs are mainly standard documents provided to the THB by Welsh Government with some minor amendments for local circumstances. The THB will put a note on the document to state that the SFIs will be internally reviewed every 2 years should a review by Welsh Government	31.12.2024		Overdue		Partially complete		**February 2025:** Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval.							mar-25	10.02.2025	
242512	Core Financial Systems - Treasury Management Final Internal Audit Report	Substantial	Director of Corporate Governance/ Director of Finance (Accounting and	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)	R2	The Standing Financial Instructions should be updated to ensure references to the Head of Financial Services are updated to the Assistant Director of Finance (Accounting and Services).	Agreed - The change to title will be made at next update of Scheme of Delegation scheduled for late 2024.	31.01.2025		Overdue		Partially complete		**February 2025:** Review of the Health Board's SFIs is currently underway, the updated version is due to be presented to the Board on 26 March 2025 for approval.							mar-25	10.02.2025	
242517	Deprivation of Liberty Safeguards Final Internal Audit Report	Limited	Director of Nursing, Quality, Women and Family Health	Jayne Wheeler Sexton	R1	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	and format (spreadsheet, table, dashboard etc). Medium Agreed Management Action Target Date Responsible Officer 1 Update DoLS policy.	31.01.2025		Overdue		No progress		20/2/25 - DoLS policy re-draft will commence upon outcome of business case as this will determine content.							mar-25	10.02.2025	

Internal Audit Recommendations with revised deadlines

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	PTHB Ref. No.				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker	for Closure Yes/No	Justification for Closure	Update received
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?								
202108	Partnership Governance – Programmes Interface	Limited	Director of Corporate Governance/Board Secretary		R1	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes. A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	sep-21	jun-25	Deadline Revised		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position. **Feb 2022** update - some high level work commenced with this action in 2022 but due to a variety of factors the work has not been completed. The new Director of Corporate Governance / Board Secretary took up post in January 2023 and will ensure the development of the partnership governacne guidance document is included for the 2023/24 year. Revised date requested to 31 March 2024. **April 2023 –** action is on track for March 2024, reports will be provided as the year progresses. **April 2023 –** The Live Well: Mental health partnership reports to each Regional Partnership Board meeting. An assurance report will also now be included to the Boards Patient Experience, Quality and safety meeting on an annual basis. The report has been added to the Committee's work plan for 2023-24. **Nov 2023 –** RPB report introduced at Board level on a bi-annual basis (first report 29 Nov 2023) with enhanced reorting of RPB Board activity at each meeting. The framework is intended to be compkleted for the target date, there is a risk of not achieving this due to staffing capacity, the Board Assurance Framework wil take priority. Feb 2024 - in Nov 2023, when the Board considered the revised annual delviery plan, the Board agreed that the action be defered to 2024/25. Recommended date change to Dec 2024. all other mitigations mentioned above continue to be in place. **April 2024 –** update as per above. Date needs to be changed to Dec 2024. **June 2024 –** action remains planned to be completed for Dec 2024. **Aug 2024 –** action remains planned to be completed for Dec 2024. **Jan 2025 –** targets date not delivered, progress made to design the approach to the partnership framework with details of range of partnerships being populated. Annual Delivery Plan updated	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	mar-24		41	#NUM!	mar-25				
202115	Winter pressures and flow management	Reasonable	Director of Planning, Performance and Commissioning		R2	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update process.	2.1 Agree - cannot action until further consultation. Recent engagement with DU has suggested DTOC will return by end of year. If this is the case policies and procedures will need recommencing & revision if required. 2.2 Flow charts & diagrams of discharge requirements circulated to staff, placed in shared access folders and discussed in team meeting. Will be a standard agenda for assurance of understanding & interpretation by staff. 2.3 The update of any policies will be in line with Welsh Government direction on DTOC and discharge planning, so we are working within national guidelines.	mar-22	apr-25	Deadline Revised		Partially complete		**Updated Dec 2024** - Guidance released in November 2024. Raised at system escalation meetings and agreed for review and system assessment against best practice recommendations. Workshop session scheduled for December 23rd 2024, with aim to provide compliance report, action plan and update to JLT in January 2025. Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements. Nov 2023- DTOC system now revised to Pathways of Care Monitoring. PTHB has been reporting on a monthly Census since April 2023 and working with the delivery unit through regular action planning. Patient pathways are embedded on admission. National guidelines for discharge have been published, PTHB local discharge guidelines under review- to work with our partners in development with aim of completion by end of January 2024. 31/1 The reluctant to leave procedure and disharge guidelines have been circulated for comment. The discahrge hospital guidance has been revised but pending an addition of the choice element TBC by WG. Delivery Unit confirmed this will be released soon. Both procedures are in line with Welsh Government guidance released in November 27/3/2024 - Management of relcutant to leave published. Discharge guidance for PTHB In draft & ready to be circulated once choice element has been published by Welsh Government. Confirmation from NHS exec this will be due "soon". **26/02/25** - Updated National guidance document finally released in September 2024, and made available to Health Board in	Dec24 - Competing workload pressures for teams, but intended for prioritisation. 27.03.2024 - Choice element needs to be added for discahrge guidance, WG advised due soon. As an interim discahrge guidance has been completed in anticapation of adding the choice element	Dec 24 - Operational practice is mitigated through compliance with system policies and processes. Early adoption of recommendations for Choice, and daily reporting in place with system escalation in place. 27.03.2024 - Mitigated with the pathways of care discharge guidance being followed. Cannot implement local choice, should be guided nationally. As an interim Pathway of Care Discharge National Guidance to	**DEC 24 –** Compliance review and action planning completed by January 2025 **01/02/2024** - Relucant to leave **28/2/24** - Discharge guidance **27/3/24 –** Discharge guidance due "soon" is the update from NHS exec, hopefully early Spring, Once released will circulate internal discharge guidance for approval & release. Draft compelte.	https://nhswales365-my.sharepoint.com/:w:/r/personal/claudia_oshea_wales_nhs_uk/Documents/The%20Management%20Of%20Reluctant%20Discharge%20Procedure%20GNP%20053.docx?d=wbbc26a1d5570481082272756 9eb2f4cd&csf=1&web=1&e=JYFX0J	36	#NUM!	mar-25		NO		
222318	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Allied Health Professions, Health Sciences and Digital	Assistant Director of Therapies and Health Science	R3	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	okt-23	okt-25	Deadline Revised		Partially complete		Meeting held with WOD 28.03.2023 - recruitment process and ESR capability to be looked into further to support achievement of this recommendation. **November 2023:** WOD engagement with ESR team and NWSSP regarding potential to strengthen process through existing TRAC/ESR systems. Delayed meeting due to WOD/NWSSP capacity but re-engaged Nov 2023 and meeting planned. Deadline revised to reflect this. **July 2024:** No progress on this action following secondment of Deputy Director of AHPs & HS for first half of 2024. Reengagement with WOD required. **December 2024** - No progress made as Deputy Director of AHPs & HS was on secondment for first half of 2024 and was then successful in getting a new role, leaving the post vacant. Reengagement with WOD required when new deputy Director in post . **February 2025 –** Review undertaken to assess feasibility of this action for delivery with view remaining that this should be acheivable with appropriate engagement. HR engaged by new Deputy Director of AHPs & HS to recommence progression of this action. Meeting scheduled for March 25 with key stakeholders to re-explore options and establish an action plan with associated timelines for delivery					17	#NUM!	mar-25	mar-23		10.12.2024	
232402	SLAs for In-reach Medical Staff	Reasonable	Medical Director/Director of Planning, Performance and Commissioning	Katie Games	R2	The structure and information held regarding the in-reach arrangements that the Health Board has in place should be reviewed to ensure that it is clear, accurate and unambiguous and can easily show the current position at any time.	Review the schedule of agreements and updated activity levels. Develop and implement new SLA service specification. Increased clarity on reporting requirements. Monthly SLA update/review meetings to be held in addition to CQPR meetings.	des-23	apr-26	Deadline Revised		Partially complete		PTHB Planned Care Manager and Information are looking at refreshing the Power BI report to ensure all theatre sessions and OP clinics are mapping to the report. Head of Commissioning in process of revising and updating the SLA templates and working with Planned Care colleagues to ensure that the activity level requirements of the SLAs are updated. Continuing to work towards development of service specifications to underpin the SLAs. **09.09.2024** - Service specification template completed, work will now take place during 2024/25 and subsequent financial years to develop service specifications to underpin the SLAs. **16/12/2024** - As above re SLA template. Work to be undertaken to have service specifications in place to underpin the SLAs during 2025/26.					15	#NUM!	mar-25				
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R2	Management should review the main Health & Safety Policy to ensure that the correct references are quoted for all supporting policies noted.	Management will review and update the Health and Safety Policy so that it reflects the correct references for supporting policies.	mar-24	apr-25	Deadline Revised		Partially complete		**Dec 24** The H&S Policy HSP001 is currently being reviewed in line with the current review period and will be submiited for approval at the next HSC meeting in April 2025 (covering Q4 2024/25). Q3 - October 2024 - All H&S policIes were updated to reflect the porfolio changes. **Feb 25** - The H&S Policy HSP001 is currently being reviewed in line with the current review period and will be submiited for approval at the next HSC meeting in April 2025 (covering Q4 2024/25).	None		jun-24		1	1491	mar-25	jan-24			
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R3	Management should undertake a review of IOSH training requirements as detailed in the Health & Safety policy, to determine which levels can reasonably be delivered by the Health Board. For the Working Safely level, management should consider whether any elements of the statutory and training modules will meet this requirement, negating the need for all staff to attend a one-day course, and update the Health & Safety policy accordingly.	Management will review the H&S training requirements, including the consideration of all training already available in the workplace and update the H&S policy accordingly	jun-24	apr-25	Deadline Revised		Partially complete		**Dec 24** The training currently identified in the policy is being reviewed as part of a wider H&S policy review which will be submitted for approval in April 2025. This review will look at the various training options avaiable and delivery methods, to ensure suitable and sufficient H&S training is identified for each role within the organisation. It has to be noted that IOSH Managing Safety Courses have been delivered to staff both face to face and online as identified in the current policy. These courses have been provided at no cost to PTHB by NPTC, with assitance of Welsh Government. Even though the delivery has been via two different methods to make it more accessible to staff, there has been little take up. There is now a charge of £185 per person to attend this course. Another option of an All Wales H&S training course currently being developed by CTM is being investigasted, but this course it not yet ready to launch. **Feb 25** - The training package being developed by CTM is not yet complete. When completed it will be sent to health boards across Wales to review and test, if suitable it will	None		jun-24		#NUM!	1491	mar-25	jan-24			
232414	Health and Safety Arrangements	Reasonable	Director of People and Culture	Assistant Director of Support Services - Health and Safety	R9	Management should ensure that: • The accountability arrangements for the Fire Safety Group are clarified and the ToR updated accordingly; • The Chair of the Security Oversight Group is reminded of the requirement to provide quarterly highlight reports to the H&S group; and • The ToR for the Site Coordination Forum are reviewed, noting the frequency of meetings requirement.	Management will clarify and correct the TOR for the Fire Safety Group in respect to its accountability arrangements. Chair of the Security Oversight Group to provide a written report for the H&S group on a quarterly basis	mar-24	apr-24	Deadline Revised		Partially complete		29/05/2024 TOR being reviewed at June HSG. H&S policy will need further work due to structure changes and will be updated in line with the new portfolio. Discussions taking place with Director of Corporate Governance, Associate Director of Estates and Exec Director Finance and Support Services to review governance of Fire Safety and other related groups. **Feb 25** - The TOR for HSC is to be approved at the April 2025 Meeting and this will be encompassed in the reviewed H&S Policy for approval at the same meeting. The TOR for both the Fire Safety and Site Co-ordinators/Security Groups were approved in Q3 2024 by the varuious groups, but a wider discusssion is now taking place with Director of Corporate Governance, Associate Director of Estates and Exec Director Finance and Support Services to review	None	0	jun-24		1	1491	mar-25	jan-24			
232420	Estates Condition	Limited	Director of Finance, Capital and Support Services	Associate Director of Estates and Property/Director of Corporate Governance/Head of Estates/Head of Technical Services/Capital Programme Manager	R3	The THB should develop an Estates Strategy for the medium and long term, to be informed by the up to date Six Facet Estate Condition Survey.	PTHB Estates Strategy is being developed and is informed by the recent 6 Facet Survey with first draft to be produced in quarter one 2024/25	jun-24	mar-25	Deadline Revised		Partially complete		The facet survey data has been utilised to inform the ongoing Better Together Site Review - the outcome of which will enable the Service Strategy to be defined and, in turn, the Estates Strategy for the long term. In the medium term, the ongoing Capital Prioritisation outcomes for North Powys, Llandrindod Phase 2 and Machynlleth business case progression endorsement, meets the needs of the short term strategy.	Significant organisation Transformation consideration underway making the 'where do we want to be' question uncertain in terms of the strategy	Known Capital investment objectives are being progressed; e.g. bid for funding to IRCF for North Powys	Target end of 2024/25 financial year		9	1491	mar-25	mar-24			
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home Governance	R2	Management should consider reviewing the circumstances for the submission of retrospective care packages in order to identify areas where improvements in communication could be made so that the Complex Care Teams are made aware of the patients sooner. This would reduce delay in submitting the packages for approval and also improve information for financial purposes.	It is recognised that the audit has highlighted the quality of compliance with our own administrative processes. The teams do struggle with capacity to meet the diverse demands generally, however, continuously strive to liaise with other teams for information. The aim is to consistently improve communication systems but there are limitations to what can be done within the current resources. Practice changes have taken place, and it is recognised that there is an interdependence between teams, although the impact falls on the performance of the Complex Care teams who cannot control the speed at which information is presented from external sources. With a small amount of additional resource to add to current practice changes, improvement in the speed of processes will occur. Both teams are mindful of patient need and out of panel decisions are made where this is necessary for timely implementation of patient care	30.06.2024	31.03.2025	Deadline Revised		Partially complete		There has been some progress and performance has seen a small improvement. Resources have been applied for through the IBG. Next step will be for Executive Committee to consider. **Dec 24** EC did not approve resource application. **February 2025** A new system has been implemented to ensure progress is within timecales.							mar-25	jul-24			
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care	R3	Management should ensure that all care packages are undertaken within the required timescales. Where delays occur management should ascertain the reasons for the delay and take appropriate action to remedy the matter.	Capacity in the teams has been reviewed and will be addressed in a business case presented to the Investments and Benefits Group for consideration of some additional resources and a Committee report scheduled for August	31.07.2024	31.03.2025	Deadline Revised		Partially complete		**Aug 24** - The team has made some efficiency improvements but without investmment this will not improve further. Executive Committee to consider the IBG paper. **Dec 24** EC did not approve the resource application and more work will need to be undertaken. **February 2025** Care that is available is implemented as soon as possible. Delays can occur through other parts of the							mar-25	jul-24			

242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Assistant Director of Complex Care/Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home	R4	Management should review the processes in place within both teams for the approval and application of annual inflationary increases in order to standardise the processes to be followed. Management may wish to consider producing a local 'desktop' procedure that sets out actions/processes to be followed for updating the NCC database.	Focussed work on annual uplifts has commenced with finance colleagues and there is a shared objective to improve the health board approach around this. We will give full consideration to improvements and timely updates on the NCCD database as part of the service review	31.12.2024	31.03.2025	Deadline Revised		Partially complete		**Aug 24** - Significant progress around annual uplift process and this work with the Finance team continues. **Dec 24** The next steps on uplifts for 2025/2026 will commence in the New Year. **February 2025** Work has commenced on annual uplifts with the Finance team.								mar-25	jul-24	
242506	Continuing Health Care and Funded Nursing Care (Final Report)	Reasonable	Director of Primary Care, Community and Mental Health	Head of Complex Care & Unscheduled Care/ Lead Nurse for Complex Care and Care Home Governance	R5	Management should, review all information that is currently recorded on purchasing orders raised for continuing healthcare packages with a view to standardising the information to be detailed across the service	Work has commenced with finance colleagues around how improvements and consistency can be achieved.	31.08.2024	28.02.2025	Deadline Revised		Partially complete		**Aug 24** - Work is underway and there will be some task and Finish groups to look at options for streamlining processes. **Dec 24** This work continues and trials have commenced to pilot new ways of working. **February 2025** As above								mar-25	jul-24	
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R1	The Risk Management Framework and Risk Management Toolkit should be reviewed in accordance with their stated version control requirements to ensure that their content is current, and in alignment with organisational strategic objectives.	The Risk Management Framework and Risk Management Toolkit will be revised as recommended.	sep-24	01.07.2025	Deadline Revised		Partially complete		**August 2024 -** Staff now in post, review has commenced and due to be reported to the Board in November 2024. Date extension requested to 30 Nov 2024. **January 2025 -** August 2024 update was correct at time, following further staff change in October 2024 capacity was limited. Issue now resolved with staff appointed, date change requested to March 2025 with a high level of confidence with Deputy Board Secretary now in post. **February 2025:** Risk Management Framework has been revised and is due to be presented to the Board for approval in March 2025. The Toolkit will then be updates to reflect the revised framework, this will be presented to ARAC in July 2025. Request extention of deadline to July 2025.	Staff capacity	Whilst the framework rev	mar-25						mar-25	jul-24	
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Deputy Board Secretary	R2	Promotion of risk management should be undertaken to ensure that all Health Board staff are aware of their roles and responsibilities, and a rolling programme of risk management training introduced to maximise their understanding and application of the contents of the Risk Management Toolkit.	A programme of risk management training and awareness will be developed and roll out will commence by 30 October 2024.	okt-24	01.07.2025	Deadline Revised		Partially complete		**August 2024 -** risk management training being reviewed and updated ready to commence roll out by end Oct 2024. **January 2025 -** training levels and approach developed and considered by the bRisk & Assurance Group. Training delivered to Board Nov 2023 and RAG March 2024. This action is a priority for further work Q1 2024/25 and into 2025/26. Date change requested to June 2025 when active	Staff capacity	Direct response to area	jun-25						mar-25	jul-24	
242508	Risk Management and Assurance	Reasonable	Director of Corporate Governance	Director of Corporate Governance	R6	Ongoing action should be taken to ensure that the BAF is populated as detailed within the covering paper presented to the May 2024 Board meeting. Furthermore, the BAF should then be subject to ongoing progress reporting to the Audit Risk & Assurance Committee and the Board.	The development of the BAF forms part of the scheduled work programme and forms part of the Board work programme for the Boards meeting on the 25 September 2024.	30.09.2024	01.05.2025	Deadline Revised		Partially complete		**February 2025:** The Board Governance Framework element of the BAF is under development and will be presented to the Board in May 2025, a fundamental review of Board level risk is underway in light of the new Integrated Plan, with a new Strategic Risk Register due to be developed by May 2025, the risk assurance elements of the BAF will also be developed in support of this work.	Staff capacity							mar-25	jul-24	
242515	Capital Systems Final Internal Audit Report	Reasonable	Director of Finance (Accounting and Services) and capital Estates	Head of Capital	R2	Expected Evidence of Implementation: • Suitable completion of the Procurement Strategy form in the PID	When Frameworks have been used, the appropriate rules of appointment have been consistently followed and are compliant. The Frameworks include tendered, competitive rates but in some instances, a further option for mini competition between Framework Suppliers is possible, which may deliver further cost	01.11.2024	01.04.2025	Deadline Revised		On track		The revised PID form will 'go live' in April to support project pipeline 2025/26								mar-25	10.02.2025	

NOTE: Report format different . Recommendations not named or listed.

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PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
242501	Review of Workforece Planning Arrangements		Director of People and Culture		R3	Once the post that has been created to improve staff retention has been recruited to, the Health Board should develop a consolidated programme of retention activities with a clear evaluation framework focusing on what impact its activities are having on improving staff retention	The retention lead will pull all of our retention activities together and undertake a self-assessment and subsequent gap analysis against the national retention plan, identifying where improvements can be made. • Staff retention rates will be measured and reported through the Health Board's Workforce Performance Framework and will Q4 2024-25 Deputy Director WOD Page 31 of 34 - Review of Workforce Planning Arrangements - Powys Teaching Health Board include analysis from staff exit questionnaires.	Quarter 4 2024/2025		Complete		Complete		Dec 24 - Workforce Retention Lead in post since February 2024. Workforce Steering Group and associated Task & Finish Groups established. Organisational self assessment and gap analysis completed against the National Nurse Retention plan, with identified areas for focus and improvement. Draft organisational workforce retention improvement plan drafted, which incorporates all actions from the nurse retention plan as well as local actions that were identifed through the organisational scoping activity. Retention/Staff Turnover rates are reported to Executive Committtee on a monthly basis and into Workforce & Culture Committee on a quarterly basis. Staff exit questionnaires are reviewed monthly. The process has been reviewed with a new approach being implemented with a view to increasing the completion rate.							feb-25	jun-24
242501	Review of Workforece Planning Arrangements		Director of People and Culture		R4	To ensure the Workforce and Culture Committee has good oversight of the overall progress and impact of delivering the Workforce Futures programme, the Health Board should develop the update reports on each of the Workforce Futures strategic priorities to clearly highlight progress against key actions and milestones as agreed in the Integrated Plan. The report should also include key metrics to illustrate progress, and the	• Provide Workforce and Culture Committee with 'in-year' updates which will identify and include progress against key metrics. These will demonstrate the impact and illustrate progress that the actions are having against each of the key workforce strategic priorities aligned to the workforce futures strategic framework and included in the integrated plan.	Quarter 1-4 2024/2025		Complete		Complete		Dec 24 - Workforce Performance data and reports are presented to Executive Committtee on a monthly basis and into Workforce & Culture Committee on a quarterly basis. Integrated plan update reports on the Workforce Futures section, which includes progress against key actions, milestones and metrics are also presented to Executive Committee and Workforce and Culture Committee on a quarterly basis. These reports clearly illustrate progress and impact of delivery.							feb-25	jun-24
242501	Review of Workforece Planning Arrangements		Director of People and Culture		R5	The Health Board should identify organisations across the UK with similar workforce challenges to benchmark its workforce performance and share good practice	• Work with the Health Boards Corporate Performance Team to try to identify similar organisations whose workforce metrics can be accessed in order to benchmark	Quarter 4 2024/2025		Complete		Complete		Dec 24 - PTHB P&C representatives meet with colleagues from across NHS Wales on a monthly basis to discuss and share best practice in relation to Workforce planning. This is through the Assistant Directors Workforce Planning Group and the WFP Network. PTHB P&C representatives have met with colleagues from a similar rural Scottish Health Organisation to share best practice and resources in relation to WFP.							feb-25	jun-24
242503	Review of Cost Saving Arrangements		Executive Director of Planning, Performance and Commissioning		R2	The Health Board should make greater use of Getting it Right First-Time (GIRFT) reviews that directly apply to the Health Board as a further source of potential intelligence to inform its savings identification arrangements	Agreed - To note The Health Board has been fully engaged and implemented GIRFT principles for its provider services where relevant and is working with other providers for commissioned services therefore already actioned.	okt-24		Complete		Complete		In place and complete. Confirmed by the audit report review of Cost Savings Sep 2024							mar-25	

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
242501	Review of Workforece Planning Arrangements		Director of People and Culture		R1	To ensure service level workforce plans are consistent, for the next planning cycle, the Health Board should ensure all directorates and/or service areas develop a workforce plan using the HEIW workforce plan template	Continue to roll out training that utilises the HEIW workforce plan template. • Provide periodical updates to Executive committee of those managers who are required to undertake the training; have done so, to ensure that the competencies to complete workforce plans are embedded within the organisation. Development of directorate workforce plans will be included as a key deliverable within the 2024-25 Integrated Plan.	Quarter 4 2024/2025		Not yet due		Partially complete		Dec 24 - Workforce planning (WFP) training continues to be available for managers to access through multiple modalities. such as 1-hour information and awareness session, through to more detailed training accessed via online or face to face classroom based training. 38 staff have completed the full training to date with leadership teams from across Mental Health, Womens & Childrens, Digital and Corporate Nursing receiving the 1-Hour awareness sessions. Gap analysis completed of those managers who have completed training and identifed those managers with workforce planning responsiblity that would benefit from the training. Identified list of managers to be shared with relevent Director/AD in Q4 for consideration. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed. HEIW have offered funding (until 31st October 2025) for a Workforce planning manager role to support the development of local MH WFP's aligned to the national strategic Mental Health WFP. The role has been advertised, interviewed and an offer made, but candidate then went on to withdraw. Role has been re-advertised again and is currently at the shortlisting stage. In order to support managers to develop WFP, WOD Business Partnering Team will share HEIW template to clinical directorates pre-populated with up-to-date workforce data - Q4. **Feb 25 -** Targetted discussion with Assistant Directors has taken place with an identifed list of senior managers to prioritise in relation to training delivery (9 of these have booked sessions). In total, the workforce planning training in line with the HEIW template has been delivered to 39 managers (through a variety of routes/approaches). Our training approach has continued to develop based around service needs and has included the devleopmet of a bespoke awareness session and more recently, targetted practical follow up sessions to explore the 6 step toolkit in more detail.	Capacity of managers with WFP responsibility to complete WFP training and subsequent WFPs. Unclear what future demand is until Route Map to Sustainability work has been defined/completed. Difficulties in recruitment to WFP Manager role.	People & Culture WFP Lead continues to develop organisational level WFPs	2025/26				feb-25	jun-24
242501	Review of Workforece Planning Arrangements		Director of People and Culture		R2	The Health Board should develop an evaluation framework to measure whether the roll out of workforce planning training is achieving its intended purpose and improving service level workforce planning	• Gain feedback from attendees both immediately after training and 3 months post training to understand effectiveness. • Measure the number of workforce plans produced across the organisation.	Quarter 4 2024/2025		Not yet due		Partially complete		Dec 24 - P&C Business Partnering Team have developed an evaluation framework which gathers feedback from attendees following the training delivery. Refreshed evaluation questionnaire due to be sent to all those that have attended training to date to understand current utilisation of WFP knowledge and skills. **Feb 25** - An evaluation form has been developed and it is anticipated this will be finalised and sent to attendees by end of March 2025. Due to a shift in organisational priorities/demands, there has been a focus on workforce planning at an organisational level to inform the annual education commissioning and pipeline development work. With the new route map to sustainabiltiy work, new priorities and service models will be developed and defined, which will then allow for more detailed, individual service level workforce plans to be developed.	Percentage of those attendees completing evaluation questionnaire.		Q4 2024/25				feb-25	jun-24
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health	Director of Primary Care, Community and Mental Health	R1	The Health Board should review the relative maturity of clusters, to reflect on the existing arrangements, address any potential gaps and strengthen Health Board support where necessary.	To continue with Accelerated Cluster Development progress, including expansion and implementation of wider collaboratives. This will include a focus on Collaborative Communication and Engagement, embedding Professional Collaboration arrangements linking in with Contract Reform Implementation and progressing cross-collaborative projects at cluster level through 'start well', 'live well', 'age well' programmes – a bottom-up approach to increase cluster maturity. Progress will be monitored via the ACD readiness checklist and assurance provided through the RPB.	mar-25		Not yet due		Partially complete		Delays with establishment of Professional Nursing Collaborative. Unlikley to be implemented this financial year. Strengthing cluster voice in RPB Exective Group - meeting being arranged to include DPCCMH input							mar-25	jul-24
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health		R3	The Health Board should examine how it can gather additional workforce data on the number and skills of all staff working within its primary care settings, in the absence of national solutions.	To capture and review workforce data across Independent Contractors and the impact of instability in primary care due to increase in demand and recruitment challenges, to include: • Identifying workforce needs in primary care • Improving workforce planning and supporting sustainability •Promoting and encouraging multi-professional working • Improving access and capacity for student training and placement opportunities to promote longer term sustainability of Powys primary care. This will inform the roll-out of the Primary Care Workforce	mar-25		Not yet due		On track		Workforce data available for GMS Contractor staff. Training provided via the P&CCA on Sustability, Resilience and Appraisal skills, development of the Nurse Education Forum, development of standardised PC Induction, working with HEIW to develop 'stay' conversations, development of a cross-contractor sharepoint site and suite of training resources, development ongoing for receptionist competency standards, Senior Practitioner in post holding multiprofessional working discussions and informing Practice plans. significant progression with student nurse training with 50% Practices hosting, non-clinical SIM training developed by P&CCA.	Contractual negotiations on workforce data reporting . Information is available for GMS Contractors only.	Regular contact with contractors with support on case-by-case basis	Following national negotiations and contract changes				mar-25	jul-24

External audit recommendations overdue

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
232401	Structure Assessment 2023		Director of Nursing, Quality, Women and Family Health		R3	Develop a framework setting out how the walkaround should operate, and the mechanisms for reporting key themes.	A framework will be developed that can be deployed and reported to both the Patient Experience and Quality Committee and the Workforce Committee. These Committees are in the process of undertaking joint committees and this will provide an opportunity to capture key messages from	mai-24		Overdue		No progress		**Jan 25** The People's Exeperience Framework is awaited from Welsh Government. Funds are available to develop a Patient Experience Lead. JD being written. **Feb 25** Peoples Experience Framework still awaited						8	mar-25	mar-24
242503	Review of Cost Saving Arrangements		Director of Improvement and Transformation		R1	The Health Board should accelerate the work of introducing the Accelerated Sustainable Model and fully quantify the potention costs and saving that will arise through its introduction in order to place its finances on a more a sustainable footing.	Agreed - The Health Board has established a programme of work around future sustainability with programme and workstream structure: - 'Task force' in place to examine three areas: • the future model (building on existing work) • options and decisions around when to achieve financial breakeven. • new opportunities based on analysis of data and benchmarking	okt-24		Overdue		Partially complete		New directorate stood up October 2024 under new Director of Improvement & Transformation post. The Route Map to Sustainability work has been progressed to a new programme delivery structure with associated Finance team representation. Case for Change, Journey to Consultation, Clinical service redesign and Estate implications in development. As options are developed these will be costed and included in financial planning. Partially complete as work accelerated however full qualtification of potential costs and savings will not come through until later in FY25/26.	Capacity in key roles/teams to work at pace on options development.	Ongoing mitigation through existing operational measures.	TBC				mar-25	nov-24

External audit recommendations with revised deadlines

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
232401	Structure Assessment 2023		Director of Corporate Governance/Director of Nursing, Quality, Women and Family Health	2	R5	The Health Board should increase the pace in which risks currently recorded on spreadsheets are moved across to the Datix risk module.	The Clinical Quality Framework will be revised as it has exceeded its date. This will be a key action for Year 2 of the Duty of Quality Implementation Plan. This may result in a different approach given the maturity of the Integrated Performance Framework (which is aligning to the Duty of Quality). The progress and plan	jul-25		Deadline Revised		Partially complete		April 2024 - plans in place and on target June 2024 - plans continue to progress with 12 teams/service areas now included within Datix. Work will continue over the summer to move more areas into the system. Full roll out may be slightly later than target but progress is positive. **Dec 24** The Health Board continue to roll out the requirement that all risks for all directorates to be captured in the RL Datix system. **Jan 25 -** The Health Board will record all risks on RL Datix by Summer 2025. Request extenstion to July 2025	National issues surrounding the once for Wales Datix system						mar-25	mar-24
242502	Primary Care Follow-up Review		Director of Corporate Governance		R4	The Health Board should develop an action plan for raising the profile of primary care in the organisation and ensuring sufficient coverage of primary	Develop a timeline for presentation of primary care reports at Executive Committee and Board level to provide regular reporting and	jul-25		Deadline Revised		On track		January 2025 - Primary Care is an active consideration across all work programmes, Committee terms of reference reviewed in May 2024 to focus Committee roles with further consideration being made for 2025/26 changes.							mar-25	jul-24
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental Health & Director of Planning, Performance and Commissionin		R5	The Health Board should improve oversight at Board and committee level of performance within primary care by: 5.1. increasing the coverage of primary care performance within its Integrated Performance Report. 5.2. increasing the focus on outcomes and experience	Progress the development of a Primary Care Dashboard as part of Integrated Performance Report presented to Executive and Board Committees. Frequency to be agreed	des-24	mai-25	Deadline Revised		Partially complete		DPCCMH commenced conversations to develop dashboard. Wealth of information available from various departments i.e information; finance, commissioning and primary care. Requires pulling into a central repository/dashboard. Ongoing assurance via relevant papers to executive committees, including Board development and Board briefing sessions							mar-25	jul-24
242502	Primary Care Follow-up Review		Assistant Director of Primary Care		R6	The Health Board should strengthen its Primary Care Services Team by: 6.1. Reviewing the resources available to ensure it has the necessary capacity to deliver local and national priorities, alongside meeting day-to-day operational and business need. 6.2. Ensure that training and development opportunities extend	in conjunction with ongoing operational requirements, including contract reform. Review resources available to increase capacity in the Primary Care Services Team. Develop a training plan for the Primary Care Services team to support succession planning and ongoing resilience.	jun-24	jun-25	Deadline Revised		Partially complete		Team resource reviewed and revised structure proposed. Work being led under the direction of DPCCMH as part of a wider Directorate workforce review. 'grow your own' approach to increas team resilience under way. Formal and informal training opportunities underway, developing the team							mar-25	jul-24
242502	Primary Care Follow-up Review		Director of Primary Care, Community and Mental		R7	The Health Board should establish a central primary care services management group to manage primary care services as a whole and maximise opportunities for	Establish a Primary Care Services Management group covering the four contractor professions to include clinical, managerial and	sep-24	mar-25	Deadline Revised		Partially complete		group established. Terms of reference to be developed to include expanding membership along with co-opted reprensentation.							mar-25	jul-24
242503	Review of Cost Saving Arrangements		Director of Transformation and Improvement/ Chief Executive and		R5	The Health Board should rapidly ensure it has a complete and thorough understanding of the skills, capacity, and resources (including in the fields of innovation and improvement) to effectively deliver the	Recruited to new Director of Transformation and Improvement post (with associated team and portfolio established) to ensure that appropriate capacity and expertise in place to support change delivery	okt-24	mar-25	Deadline Revised		Partially complete		New directorate stood up October 2024 under new Director of Improvement & Transformation post. Resource plan for delivery of Improvement & Transformation activity will be included in Better Together programme and wider Improvement activity.	Capacity in key roles/teams to identify additional resource requirements	Ongoing mitigation through existing team deployment to areas of highest	TBC				mar-25	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.6

Audit Risk and Assurance Committee	**Date: 11 March 2025**
Subject:	**FINANCIAL CONTROLS 2024/25**
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services
Prepared by:	Deputy Director of Finance Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

To inform the Audit Risk and Assurance Committee of the financial controls in operation during 2024/25 financial year within the Health Board.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the paper and take **ASSURANCE** that appropriate controls are in place across the Health Board.

Approve/Take Assurance	Discuss	Note
N	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Financial management underpins all Health Board activity.
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	

EXECUTIVE SUMMARY:

Standing Orders and Standing Financial Instructions are at the forefront of all business the Health Board conducts. In recognition of a worsening financial position additional scrutiny and processes have been introduced to ensure tighter control of the expenditure the Health Board commits. A number of these are explained in this paper.

CONTROLS IN OPERATION:

Standing Financial Instructions and Scheme of Delegation

Local Health Boards in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. The Standing Orders for PTHB and Glossary of Terms, including the Standing Finance Instructions and Scheme of Reservation and Delegation of Powers are available via the attached link:
Board Governance - Powys Teaching Health Board

The organisation currently has four key limits in operation for the approval of expenditure. These are as follows:

ORACLE REQUISITIONS	Authority Delegated to
Up to **£10,000**	Nominated Budget holder for specific cost centres
£1,000 to **£25,000**	Assistant Directors
Up to £50,000	Executive Directors
Up to £100,000	Chief Executive

Having relatively low values to Assistant Director level at £25k means that the Executive team have sight of all significant purchases or contracts.

Procurement Threshold

Value1	Minimum Competition2	Lead	Waivers, or exceptions to tender rules
Up to £5,000	Best value to be shown	Budget owners	-
£5,000 to £24,999	3 quotations	Procurement Services	Head of Procurement or Director of Finance or CEO

£25,000 to OJEU threshold for supplies and services3 **£25,000** to **£1m** for works	**4 tenders**	Procurement Services	Single Tender Action Authorised by CEO
Above OJEU threshold for supplies and services3 to **£1m**	**5 tenders**	Procurement Services	Single tender action prohibited
Above OJEU threshold for works4	**Procured via Designed for Life: Building for Wales**	Procurement Services	Single tender action prohibited
Over **£1m (other than D4L)**	**WG approval required**	Procurement Services	-

1 Total value excluding VAT.
2 Subject to existence of suitable suppliers
3 Threshold from January 2014 for Supply and Services is £111,676
4 Threshold from January 2014 for works is £4,322,012

Advice from the Procurement Services, provided by NHS Wales Shared Services Partnership, must be sought for all requirements in excess of £5,000 and the THB is able to take advantage of economies of scale of All Wales Clinical and Non Clinical consumables contracts in operation.

Non Pay Scrutiny Group

A Non-pay Scrutiny Group (NSG) has been established in the Health Board and meets on a weekly basis. All orders for non medical/clinical goods and services are automatically flagged by the Procurement Team, and any orders greater than £1,000 are reviewed by the Non-pay Scrutiny Group.

The group asks the following types of questions:

- Is there a clear and compelling rationale for this expenditure?
- Is this needed now or can we wait until next year?

Where they have any queries these are followed up with the approving manager. This process aims to be a helpful and constructive way to maintain costs to help us live within our means, including helping managers identify alternative approaches that may be more prudent.

Long Term Agreements/Service Level Agreements

The Health Board commissions healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The commissioning department oversees that the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

The Health Board receives monthly contract monitoring returns alongside detailed patient datasets which identify activity and price for prior months.
The finance team support the commissioning team in validating and giving assurance on the information supplied, and the Health Board also works with an

English Commissioning Support Unit to validate and suport challenges related to services commissioned from English providers.

Regular CQRM (contract oversight) meetings are held with all providers, lead by the commissioning team and supported by finance, quality and operational colleagues to ensure the Health Board is receiving appropriate and best value care for our patients.

The pharmacy team at PTHB also supports control by validating all high cost drugs spend, raising challenges related to formulary used, price charged and categorisation of drugs.

Payments are made to providers on a monthly basis, calculated using the contract values set for the financial year, a schedule of which is shared with all relevant finance and commissioning coleagues, and approved by DoF prior to payment.

Continuing Health Care

The expenditure area of Continuing Health Care (CHC) contracts is supported by an All Wales operational framework outlining clinical processes and assessment practices to be undertaken. The financial aspect of the process is heavily scrutinised via Resource Panels and financial management oversight and activity data.

Routine, formal reviews are conducted annually, alongside informal reviews and care plan revision. High need and high-cost placements are reviewed as a priority and in the case of enhanced care, predominantly within MH & LD, these are tracked and reviewed through the weekly panel process. This mean that a clients condition is monitored for any deterioration/improvement and the package amended (if required) based on that review.

Payments are made to providers once authorisation has been obtained at Panel and the organisation limits in operation for the approval of expenditure has been completed.

This remains a significant increasing expenditure area for PTHB based on the aging population, complexity of care needs and increasing rates charged for such placements.

Primary Care Expenditure

Within primary care there is the prescribing drugs budget and four areas of contractor payments:

- General medical services
- Dentists
- Community pharmacists
- Opticians

The majority of contractual primary care payments are made centrally by NWSSP, the values are driven by NHS Wales agreed contract terms and conditions.

All Health Boards are sighted on the expected contractual payments and reconcile payments made against expected values. Where identifed, any discrepancies are then reported back to NWSSP. The Health Board maintains detailed working papers to ensure these reconciliations are as tightly scrutinised as possible.

Where payments are made against variable activity claims, there is a post payment verification process, centrally commissioined and delivered external to THB. The THB is made aware of any discrepances and will become involved should further investigation be required.

Any non-contractual payments will be processed through the internal THB procurement and approval processes.

The THB works with primary care providers to encourage the most cost effective means of dealing with conditions which do not have detrimental impact on the patient and regularly reviews data for any outliers to peers in this area.

The Health Board works closely with dispensers across Powys to ensure that best value of money is acheived on behalf of the Powys patients. Payments are controlled and processed centrally and the Health Board actively reconciles and scrutinises expenditure.

Pay Expenditure

As well as requirements outlined in the Standing Financial Instructions additional measures have been implemented during 2024/25. The Board supported the immediate delivery of variable pay reductions through reduced use of agency and locums and a vacancy freeze for all posts to be overseen by the revised vacancy control process. Two of the key processes in support of this area are outlined below:

Variable Pay Group

The Variable Pay Group is chaired by the Executive Director of Finance and includes Deputy Directors, Assistant Directors, and service leads. The primary purpose of the group is to reduce reliance on agency staffing across operational services through the following measures:

- Detailed management information to inform workforce planning.
- Improved monitoring and challenge of operational practices.
- Clear pathway for requesting agency staff to eliminate unnecessary agency spend.
- Understanding the reasons behind agency usage on each occasion.
- Effective rostering and use of bank staff.

- Staff engagement and recruitment of bank staff. Increased permanent recruitment of staff.

In Quarter 4, further enhancements to the Healthboard Agency scrutiny process have been implemented. All agency requests are now required to be reviewed and authorised at every level, with final authorisation by an Executive Director or Gold On Call.

In recognition of the impact this group would have within this area of expenditure within THB operational areas, an internal audit report titled Agency Spend Reduction Group was reported in April 2024 which looked at the framework of the group. The report outcome was an assurance rating of Reasonable and the two medium recommendations made are being monitored via the Audit recommendation tracking process.

Vacancy Control Process

In 2023/24, a Vacancy Control Panel comprising Deputy and Assistant directors and trade union representation was introduced to scrutinise recruitment to non-clinicial roles. This helps us manage our vacancies, recruit to the right roles, develop the people and the talents that we have, and improve our financial outlook.

From Quarter 4, additional scrutiny of recruitment and vacancies has been introduced. The Vacancy Control Panel has been replaced by a process, which requires explict Executive Director consideration of vacancies.

Other than in highly exceptional circumstances, recruitment will only take place if one the following criteria is met:

- Clinical roles that would present an immediate patient safety risk if not filled.
- Roles that incur a greater cost if they are NOT filled (e.g. because it is essential work that would need to be covered by agency staff).
- Roles which are deemed essential to supporting the Health Board to improve our financial position.
- Roles that are statutory in nature.

Investment and Benefits Group

The Investments and Benefit Group (IBG) is a sub-committee of the Executive Committee. It is a Health Board wide process to support the management of revenue business cases. As part of IBG there is a panel that supports the Executive Team in overseeing the management of investment business cases (revenue) to ensure they are in line with the board's strategic goals and corporate objectives. The main aims are to assess business cases for quality assurance, governance and value for money and to receive post implementation evaluations of the extent to which intended benefits have been achieved.

Budgetary Control and Savings & Integrated Quality and Performance Framework

The Health Board's budgetary control framework outlines the financial control requirements to ensure that the Powys Teaching Health Board (PTHB) operates within its allocated resources.

Key aspects of this framework include:

- Ensuring that all principal budget holders sign accountability letters. These letters set out the Health Board's budgets in line with the board approved plan, including staffing establishments.
- Budget holders are responsible for managing their delegated budgets and ensuring compliance with financial control procedures. They must regularly review financial management procedures and adhere to the standards set out in the document. Regular training is provided by the Finance team.
- The Chief Executive, advised by the Executive Director of Finance, determines the required savings for the year. The Finance Directorate monitors progress on savings targets throughout the year and reports both internally and externally through the Health Board's savings tracker.
- Meetings are held with all budget holders throughout the year, and at least quarterly with Assistant Directors, Deputy Directors and Directors. These meetings are supported by regular enhanced financial dashboards outlining the year-to-date position, the forecast, and the status and forecast of savings schemes.
- In addition, the Health Board conducts quarterly directorate performance reviews led by the CEO and the Performance team, which include a review of the directorate finances.
- The CEO and Director of Finance also meet with each Executive Director individually to discuss the status of their savings plans and financial performance.
- The organisational Integrated Quality and Performance Framework has a specific mechanism at Level 2B with arrangements to escalate, monitor and support services with financial management concerns or overspend.

Audit Wales recently reported to the October 2024 ARAC meeting its report on Review of Cost Savings Arrangements at Powys Teaching Health Board. The report outlined that while the Health Board met its agreed deficit target for 2023-24, its recent track record of delivering against its overall savings targets is very variable. Given the Health Board's challenging current financial position, it urgently needs to accelerate work on introducing a new, more financially sustainable service model and to ensure it has the necessary skills and capacity to support the changes required. A paper regarding the structure and capacity of the Finance Directorate is being considered by Executives. Work is being taken

forward via the Better Together programme for changes to the model of services in the medium term.

Income

Income outside of Welsh Government funding support is minimal in both value and nature. Healthcare agreements for services provided to PTHB to other bodies is subject to the same review as that outlined within Health Care Agreements Section above and the main sources of income are related to funding for projects by external bodies such as national charities such as Macmillan or Arts Council for Wales.

Internal Audit

There is a programme of regular internal audit reviews of financial and operational controls. This provides an independent source of assurance to the organisation over whether controls are appropriately designed and operating effectively. Recent reviews of financial systems have received the following assurance ratings:

- Budgetary control (2021/22) – substantial
- Treasury Management (2024/25) – substantial

NEXT STEPS:
None required as a result of this paper.

IMPACT ASSESSMENT - NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.7

Audit Risk and Assurance Committee	**Date: 11 March 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:	

PURPOSE:

The purpose of this report is to update the Audit Risk & Assurance Committee on key areas of work undertaken by the Local Counter Fraud Specialists during 2024/25.

RECOMMENDATION(S):

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
N	N	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 2024/25.
HEADING:
See attachment

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

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS 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			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Item 4.7b

Counter Fraud Update Report

11th March 2025

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. Resource allocation represents total resource days planned for the financial year. Resource used represents days used up to the date indicated.

Strategic Area	Resource Allocated For 2024/25	Resource Used Up to 19th Feb 2025
Strategic Governance	**40**	**42**
Inform and Involve	**55**	**61**
Prevent and Deter	**113**	**85**
Hold to Account	**100**	**93**
TOTAL	**308**	**281**

4. STRATEGIC GOVERNANCE

A finalised model outlining potential future counter fraud arrangements for NHS Wales, devised and agreed by Counter Fraud Specialists, was presented to DoFs Group. DoFs supported the model in principle as a way forward. Following discussion at Counter Fraud Steering Group a sub-group was established to explore the model further and take forward an action plan. The Health Board's Head of Counter Fraud Services sits as a member of this sub-group. The sub-group met in February for a first meeting with terms of reference set and agreed along with an outline plan to take forward.

The Home Office has issued formal Government guidance relating to the Economic Crime and Corporate Transparency Act 2023. The intent of this new legislation is to

establish wide ranging reforms to tackle economic crime and improve transparency over corporate entities. The. The Act will bring in amendments to Proceeds of Crime Act 2002 confiscation and civil recovery powers primarily aimed at cryptocurrency as well as strengthening of anti-money laundering powers.
The Act has also introduced a new offence of 'Failure to Prevent Fraud' this is where a relevant body is guilty of an offence if, in a financial year of the body a person who is associated with the body commits a fraud offence intending to benefit that body or persons connected with the body. This new offence will come into effect on 1 September 2025. There is a defence to this offence of an organisation having in place such prevention procedures as it was reasonable in all the circumstances. The fraud prevention framework put in place by relevant organisations should be informed by the following six principles to meet this defence:

- Top level commitment
- Risk assessment
- Proportionate risk-based prevention procedures
- Due diligence
- Communication (including training)
- Monitoring and review.

Initial assessment suggests that through compliance with NHS Counter Fraud Standards which align to these principles the Health Board is at low risk to exposure to prosecution with current counter fraud arrangements. The NHS Counter Fraud Authority will be issuing NHS specific guidance. A full review will be undertaken in line with this guidance once issued and a report brought for this Committee's attention.

5. INFORM AND INVOLVE

The Counter Fraud Team have undertaken a strategy meeting in relation to inform and involve work with a view to increasing reach, attendance at general fraud awareness training, and quality of Counter Fraud output. The Team have decided on direction to:

- Increase the availability of face-to-face training sessions from Q4 2024/25 going forward
- Engage with Communications to gain advice on visibility and reach of training booking links
- Revitalise the Counter Fraud Newsletter and align to more up-to-date styling and production methods
- Produce refreshed information booklets and leaflets around NHS Counter Fraud
- Explore use of AI tools to support styling and graphics production to professionalise output

6. PREVENT AND DETER

The first set of matched data reports has been issued to the Health Board via the National Fraud Initiative. The matched data sets will be reviewed throughout Q4 with an aim to complete first checks and applicable data checks by the end of the financial year. A progress report will be brought to this Committee in summer 2025.

7. HOLD TO ACCOUNT

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

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

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

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.8

Audit Risk and Assurance Committee	**Date: 11 March 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:	None

PURPOSE:

To inform the Audit Risk and Assurance Committee that there has been one Single Tender Waiver request made between 1 January 2025 and 28 February 2025

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** there has been one Single Tender Waiver request made between 1 January 2025 and 28 February 2025.
- Take **ASSURANCE** that the organisation has appropriate monitoring in place for single tender waivers.

Approve/Take Assurance	Discuss	Note
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	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 January 2025 meeting which covered the period from 1 October 2024 and 30 December 2024.

A summary of the use of Single Tender Action from 1 January 2025 and 28 February 2025 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
2425-038-STA-POW	TENDER	DEKOMED LTD	Value for Money and Consistency to previously purchased equipment for programme	Continuation of work linked to previous undertaking	15/01/2025	£34,120	N/A	Prospective	A1

NWSSP Procurement use a central register now for the majority of Health Boards that use a physical waiver document process and the reference and number is auto generated based on its position on the list. Although the above table states it is 038 STW document issued it is confirmed this is the second STW undertaken within Powys for the 24/25 financial year.

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.9

Audit, Risk and Assurance Committee	**Date: 11 March 2025**
Subject:	**Information Governance Key Performance Monitoring Report**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Head of Information Governance, Records and Data Protection Officer, Document and Records Manager and Information Governance Manager
Other Committees and meetings considered at:	Executive Committee - 19 February 2025 – who supported the report.

PURPOSE:

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

RECOMMENDATION(S):

The Committee are asked to:

- **RECEIVE** the report and take **ASSURANCE** on areas of good compliance, acknowledging efforts and successes.
- **NOTE** areas of poor or non-compliance and take **ASSURANCE** a programme of work is in place to improve compliance.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	IG contributes 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	

EXECUTIVE SUMMARY:

This reporting period covers Quarter 3 2024/25, with a high-level overview of performance listed below, and more detailed breakdown provided in the detailed background and assessment section.

Freedom of Information (FOI) and Environmental Information Regulations (EIR) Requests:

- **104** requests received
- **6** breaches. The longest breach was 43 days (reason due to service delays), the legislative timeframe is 20 working days.
- FOI compliance **94%** which remains above the Information Commissioner's target of 90%.
- Figures for this quarter remain consistent with the last quarter.
- **2** requests received for an Internal Review, following our response no further action has been taken by the requestor.
- No EIR requests have been received

New developments

The team have started working with other health board services to identify information requests that can be made more readily available to the public within the Health Board's Publication Scheme. Providing this additional information should lessen the burden on services where questions have been similarly answered in the past and provide the public with greater access to corporate information.

Requests for personal information:

- **211** requests for personal information received (living and deceased)
- **3** breaches under UK GDPR timeframe (1 calendar month), longest breach is **117** days, which is ongoing, and is due to a service failing to provide records within the legislated timeframe due to the requested records being stored in an unsafe location. IG are continuing to work with the service and Estates & Facilities teams to rectify and will provide an update in the next Committee Report.
- Zero breaches in Access to Health Records Act (deceased).
- Compliance this quarter has increased to **98%** (compared with 96% last quarter) and remains above the locally agreed target of 90%.
- Total number of requests has marginally decreased compared with Q2, however the Committee is asked to note that compared with Q3 2023/24 there has been a **21%** increase in requests received.
- The complex nature of requests being received is demanding a considerable amount of the Team's resource to ensure thorough reviewing and redacting of information. Consequently, this is diverting focus and time from advancing other critical priorities in our workplan.

Individuals Rights under UK General Data Protection Regulation (UK GDPR) - Requests for rectification, erasure, and restricting processing:

- **3** requests for erasure/rectification received

IG Training and Awareness:

NHS Wales IG Mandatory E-Learning: The overall compliance rate for the health board is **88.7%** remains above the national target of **85%.**

New starters: Out of the **110** new starters, **105** had not completed their IG mandatory training within the first 6 weeks of employment (national requirement). A new process has been implemented this quarter to specifically target these staff with the aim of ensuring training is completed. An update will be provided in future reports.

Internal Training provided by IG - **10** bespoke training sessions have been delivered covering the following areas:

- Information Asset Register and Introduction to IG.

Datix Incidents (Breach Reporting):

- **38** Information Governance related incidents reported,
- **18** incidents were not reported within the UK GDPR regulatory 72 hours, mainly due to service delays in reporting.
- None of the recorded incidents were deemed reportable to the Information Commissioner's Office (ICO).

The top five themes identified during this reporting period:

- Unintended recipient external (letter, email) – **9** incidents
- Breach of sensitive data – **3** incidents
- Patient records / information inappropriately divulged – **3** incidents
- Records Management – Missing records/ documentation – **3** incidents
- Records Management – Patient record misfiled – **3** incidents

Services continue to be supported with identified actions and mitigations to avoid further reoccurrence of similar incidents.
Themes and lessons learnt from these incidents also influence IG training sessions, news items and Policy and Guidance development.

Challenges:
Challenges: Although there is a marginal improvement in the timeliness of services logging incidents within the 72-hour window, the delays are still proving an issue, which would, should any of these incidents be reported to the ICO be picked up as a concern.

Reminders have been issued out via several channels including Datix training sessions to try and reduce the numbers.

Large volumes of non-IG related incidents continue to be received into the team due to services incorrectly assigning the incident as having IG relevance:

- October – Non-IG notifications - **22**
- November – Non-IG notifications - **9**

- December – Non-IG notifications - **17**

Top 3 Non-IG Incident Themes:
- Patient behaving in aggressive manner – **11**
- Pressure Damage / Moisture Damage – **6**
- Patient Falls - **3**

Amending these incidents take un-necessary resource within the team. Reminders have been issued to staff highlighting this concern however high numbers continue to be received. National feedback is this is a common problem across Wales.

Audit and Monitoring:

The National Intelligent Integrated Audit Solution (NIIAS): During this reporting period:

- **3** notifications of staff potentially accessing their own record (1st offence)
- **6** notifications of staff potentially accessing a family member's record (Home Relations First Offence). These have all been investigated, with none of the 6 incidents requiring reporting to the ICO.
- **1** notification of staff potentially accessing their own record and a family member. This was investigated, and did not require reporting to the ICO.

Other audits:
Internal Audit revisited Records Management in Q3, the final report has been issued with assurance awarded as 'substantial'. Work is ongoing to address one medium priority recommendation made relating to fire suppressions systems within records storage locations.

Information Asset Register: During Q3 **41** assets were added to the new platform. Work continues to engage with services to encourage them to upload their assets to improve compliance.

Policies & Procedures: The following new and updated policies and procedures were completed during this reporting period:

Updated
- IGP 007 Health Records Procedure
- IGP 010 Access to Information Procedure

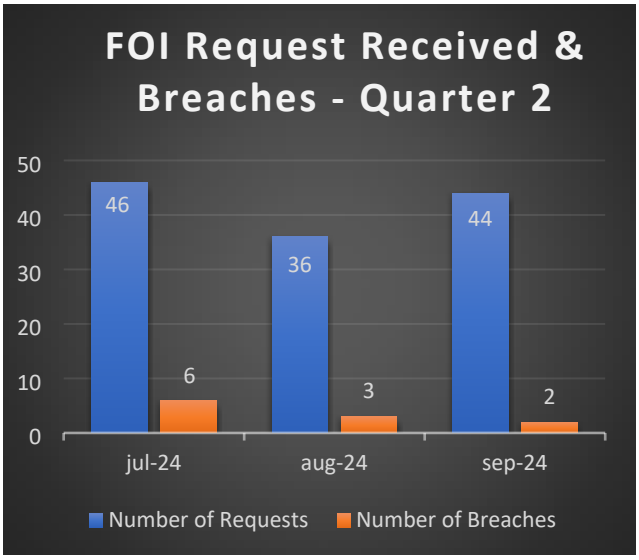
New
- IGP 024 Records Storage Request Procedure
- IGP 023 Policy on Audio and Visual Recording by Patients and the Public

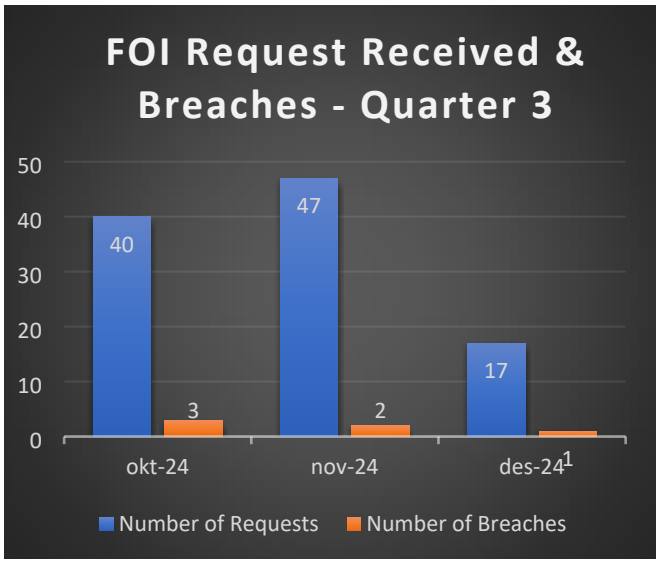
News items shared by IG: The following Information Governance & Records Management News items were shared health board wide in Q3.

- Datix Common Themes
- Records Storage Requests
- Subject Access Requests FAQ's
- Guidance on PII in Outlook calendars

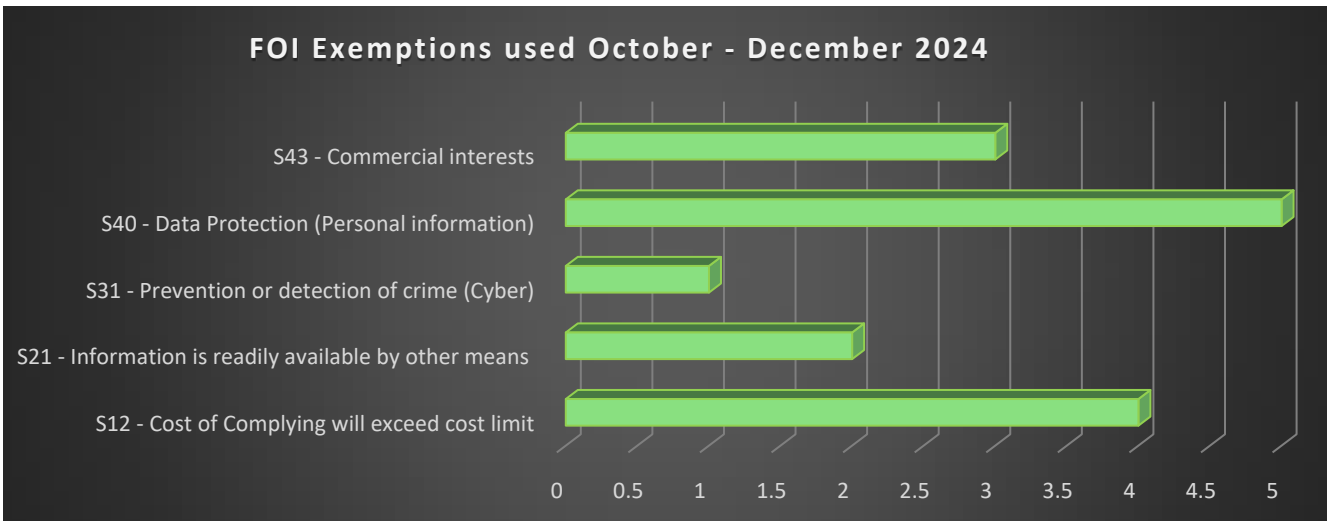
DETAILED BACKGROUND AND ASSESSMENT:

Number of FOI and EIR Requests received and compliance:





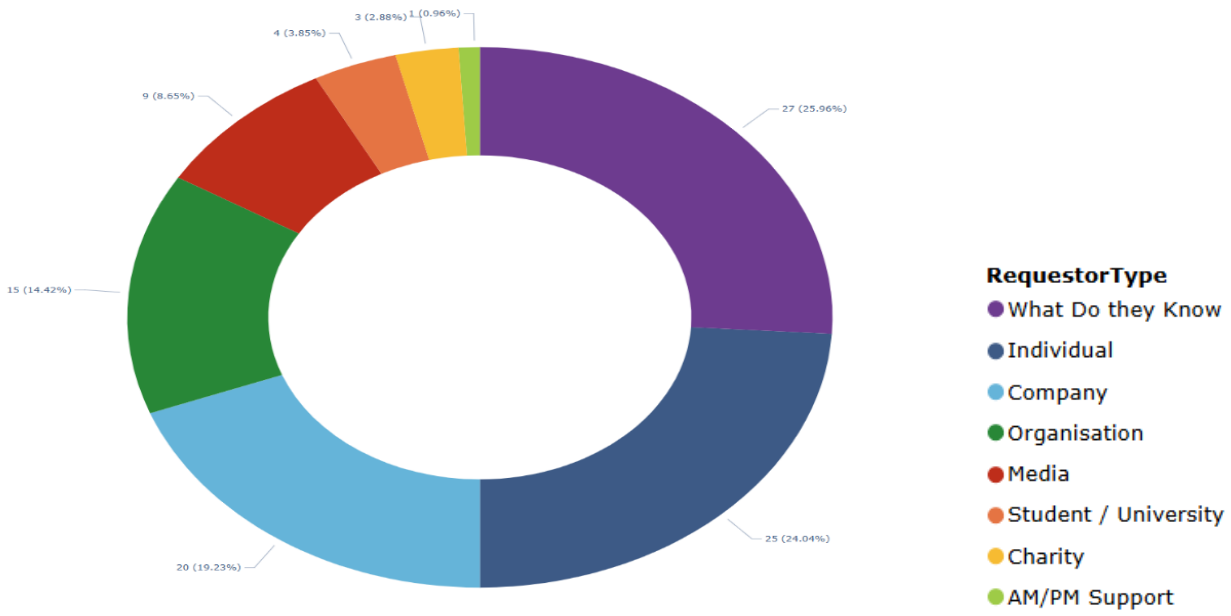
Top five FOIA Exemptions used:



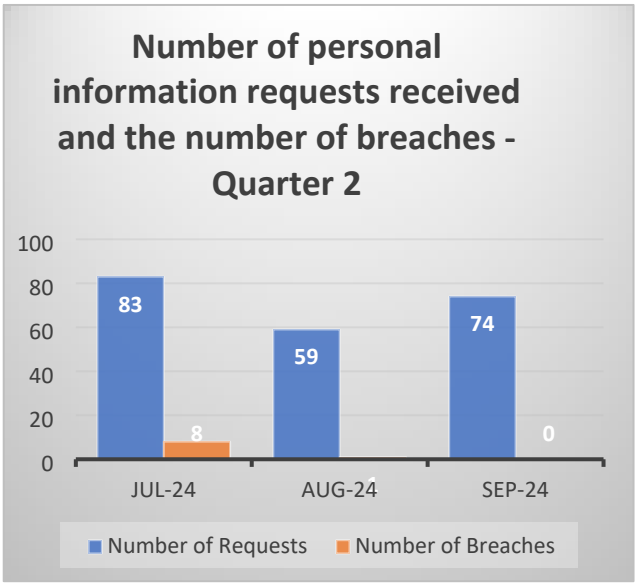
The main causes for the 6 breaches were:

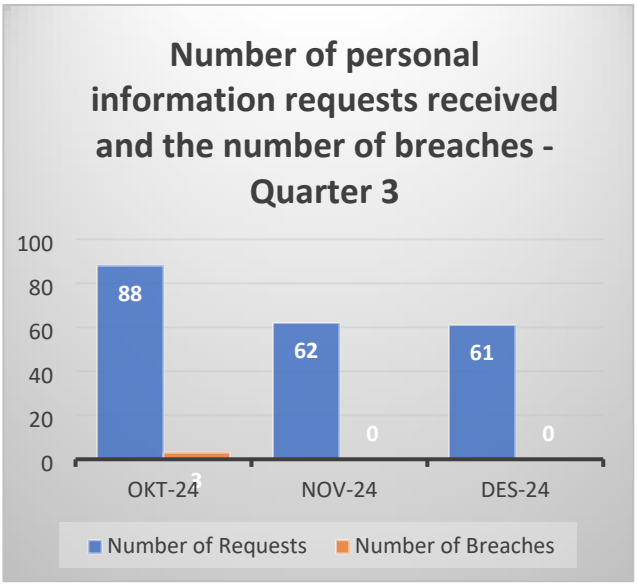
- Service delays in providing responses within the timeframe.
- Increased number of complex requests.
- Holiday period, staff on leave.

FOI Requestor Type October – December 2024:



Requests for personal information (living and deceased) compliance:



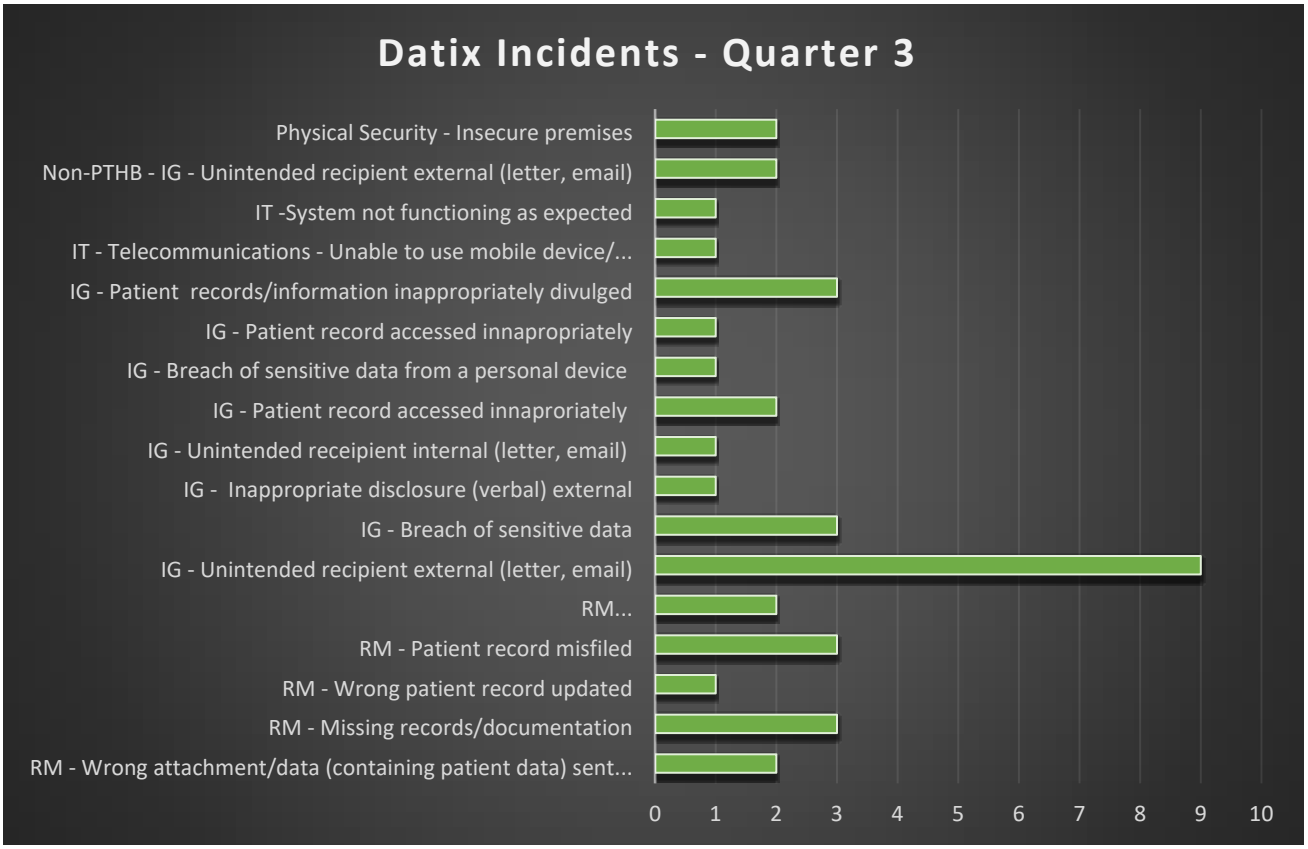


The main causes for the 3 breaches in Q3 were:

- Complexity in downloading CCTV images securely
- Service unable to be retrieve requested records from archive storage location due to Health & Safety reasons

Medical Examiner Service requests - Two disclosures exceeded the 72-hour expected timeframe, due to delay in receiving notes from the ward.

Datix Incidents broken down by theme:



Information Governance Training:
The table below shows a breakdown of IG Training compliance for new starters during Q3 2024/25:

Mandatory IG Module Completion	Headcount	Compliance %
Prior To Joining	0	0%
Not Completed	**91**	**83%**
Completed within 6 Weeks	5	5%
Completed after 6 Weeks	14	12%
Grand Total	110	17%

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

Directorate	Assignment Count	Required	Achieved	Compliance %
Chief Executive Office	20	20	16	80.00
Community Care & Therapies	1026	1026	923	89.96
Community Dental Service	69	69	56	81.16
Corporate Governance	15	15	13	86.67

Estates & Works	48	48	45	93.75
Finance Directorate	90	90	83	92.22
Facilities & Support Services	213	213	162	76.06
HCRW	77	77	63	81.82
Medical Directorate	16	16	11	68.75
Mental Health	453	453	391	86.31
Medicines Management	36	36	35	97.22
Nursing Directorate	36	36	34	94.44
Public Health Directorate	85	85	85	100.00
Planning Directorate	35	35	34	97.14
People & Culture Directorate	61	61	57	93.44
Primary Care	24	24	22	91.67
Therapies & Health Sciences	19	19	17	89.47
Women and Children	233	233	204	87.55
Grand Total	2556	2556	2251	**88.07**

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

Information Asset Register training is also available upon request and a targeted exercise will be undertaken to engage with Information Asset Owners and Administrators to ensure ongoing support and compliance.

NEXT STEPS:

- Explore ways of further improving IG knowledge around the organisation through group awareness sessions, training and digital methods.
- Continue to work closely with services to identify and reduce the delays and breaches with the processing of requests for information**.**
- Undertake an in-depth analysis of mandatory training levels for new starters and directorates who are currently below 85% and look for opportunities to increase compliance.

- Continued assurance reports will be submitted to the Committee quarterly

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe					A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
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					A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial					
Corporate					
Operational					
Reputational					

AUDIT, RISK AND ASSURANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 14 JANUARY 2025 AT 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Steve Elliot	SE	Independent Member (Finance) (Chair)
Ronnie Alexander	RA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
IN ATTENDANCE		
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Carl Cooper	CC	PTHB Chair (observer)
Mathew Evans	ME	Counter Fraud
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive (for Item 3.8)
Bethan Hopkins	BH	Audit Wales
Louisa Steel	LS	Lead Local Counter Fraud Specialist
Erin Terfel	ET	Audit Wales
Elizabeth Patterson	EP	Interim Head of Corporate Governance (Committee support)
Sarah Pritchard	SP	Head of Financial Services
Claire Roche	CR	Executive Director Nursing, Quality, Womens and Family Health (for Item 3.2g)
Sue Tilman	ST	Post Payment Verification
Hayley Thomas	HT	Chief Executive Officer
Ian Thomas	IT	Independent Member (Generic) (Observer)
Laura Tovey	LT	Audit Wales
Ian Virgil	IV	Internal Audit
APOLOGIES FOR ABSENCE:		
Amanda Legge	AL	Post Payment Verification
Hywel Pullen	HP	Deputy Director of Finance

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/24/062)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (ARA/24/063)
No declarations of interests were received in addition to those already on the register.
2. CONSENT AGENDA BUSINESS

No items were raised.

3. ITEMS FOR APPROVAL, RATIFICATION OR DECISION

3.1 MINUTES OF PREVIOUS MEETING (ARA/24/064)

The minutes of the meeting held on 10 October 2024 were **CONFIRMED** as an accurate record subject to the following amendment on page 4:

- The *report finds five areas of assurance as substantial, noting the* organisations current situation of enhanced monitoring for planning, *strategy* and finance. *The committee also note the possibility that this escalation may increase to targeted intervention at future review points by Welsh Government.* ~~However not a contradiction does not correlate with the level of assurance reported in this interim report, but it does~~

The audit process does not embrace patient experience which is of particular importance in relation to End of Life Care. Where is this considered?
HB advised that patient experience had not been included in the audit brief for End of Life Care. When planning audits particular attention should be given to the inclusion of patient experience where appropriate.
HT confirmed that the Patient Experience, Quality and Safety Committee monitored patient experience for all services.

3.2 ACTION LOG (ARA/24/065)

HB noted that three actions were recommended for closure and one action was at risk requesting a date change:

- ARA/24/16 – production of the audit handbook had been delayed due to staffing challenges. Requested date change to March 2025.

The Committee **RECEIVED** and **NOTED** the Action Log and **AGREED** the date change.

4. ESCALATED ITEMS

There were no items for inclusion in this section

5. ITEMS FOR ASSURANCE

5.1 INTERNAL AUDIT PROGRESS REPORT 24/25 (ARA/24/066)

IV introduced the progress report highlighting that the Executive summaries of the Final reports were included in section 7 of the Progress report as finalised since the last Audit Risk and Assurance Committee in October 2024. Full copies of the final reports are included at item 5.2 on the agenda.

<u>Current position with progress of the 2024/25 plan:</u>

- Nine audits finalised to date (seven since the last meeting)
- Five audits are currently work in progress with planned delivery through the reminder of the year
- Six audits are at the planning stage
- Five audits are yet to be started
- The final audit (Local Primary Mental Health Support Services) has been proposed for removal due to on-going significant delay in agreeing the scope for the audit which means resource is no longer available for delivery.

IV noted the remaining audits to be completed in year would be challenging for the Internal Audit team, and for the Committee receiving a high number

of completed audits in March and May, however, it is anticipated that they will be finalised in time to complete the Annual Internal Audit opinion.

Three key performance indicators are green, one is amber (report turnaround – management response time), however, engagement is good, and audits are being agreed, and one is red (audit reports to be agreed at Audit Committee).

IV had met with Independent Members and discussed the Audit Plan 2025/26. In conjunction with Executive leads and the Chief Executive this would be developed in the coming weeks and brought to Committee for approval.

The Committee raised the following question/observations:
Given a large number of reports are presented to this meeting and expected to the next two meetings could future reports be released to Committee Members when available to enable appropriate time for Members to read and absorb them?
IV confirmed there would be no problem releasing the reports to Committee Members providing they were not publicly released until they had been considered at Audit, Risk and Assurance Committee and would speak to HB in this regard.
Action: IV and HB to agree arrangements for timely release of Internal Audit Report to Audit, Risk and Assurance Committee members.

What contingency arrangements are in place if it is not possible to complete the audit programme in year?
IV advised that for audits which had been undertaken and the reports were in draft it would be possible to finalise these reports for inclusion in the 2024/25 audit opinion. If it was found not possible to complete the plan, then a discussion would take place as to the key areas of focus required to inform the annual audit opinion.

When completing an audit is there a timeframe to follow to ensure the work is not rushed?
IA confirmed that Internal Audit worked to international audit standards.

Does the delay in relation to the Local Primary Mental Health Support Services rest with the Health Board or Internal Audit?
HB confirmed the delay in agreeing the scope rested with the Health Board. It had been a period of significant change in senior management for this area and this had been discussed with Internal Audit in the monthly meetings between IV and HB.

Can themes be identified across the completed internal audit reports?
HB confirmed that at the March meeting IV would present the annual report on key themes and messages. The actions in internal audit reports were now attributed to themes which helps link into audit recommendation tracking.

The Committee:

- **NOTED** the Internal Progress report, including the findings and conclusions from the finalised audit reports, and
- **APPROVED** the adjustment to the 2024/25 plan.

5.2 INTERNAL AUDIT REPORTS (ARA/24/067)

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

a) Core Financial Systems – Treasury Management (Substantial Assurance)
b) Board & Committee Structure / Effectiveness (Substantial Assurance)
c) Records Management (Substantial Assurance)
d) Staff Retention (Reasonable Assurance)
e) Capital Systems (Reasonable Assurance)
f) Energy Management (Reasonable Assurance)
g) Deprivation of Liberties Safeguards (Limited Assurance)

a) Core Financial Systems – Treasury Management (Substantial Assurance)

IV presented the report which evaluated and determined the adequacy of the systems and controls in place within the Health Board for Treasury Management.

The report notes that Treasury Management systems should be regularly reviewed. What frequency is meant by 'regularly'?
IV advised that regularly generally meant every 2-3 years but some systems would require more regular review.

How are internal audit findings of reasonable/substantial etc weighted?
IV advised that audits are structured to deliver across a number of objectives. These are collated to give an overall assurance rating. The priority level of matters highlighted will help ascertain what assurance rating is settled on.

b) Board & Committee Structure / Effectiveness (Substantial Assurance)

IV presented the report which evaluated the Health Boards Board and Committee structure and assessed the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision-making on areas of accountability.

c) Records Management (Substantial Assurance)

IV presented the report which reviewed the arrangements for managing records within the Health Board and ensuring compliance with standards and regulations.

The significant improvement on the previous position in relation to Records Management was noted.

Would the significant matter relating to a lack of fire suppression in record storage areas be expensive to rectify?
HB advised that a feasibility report was being produced to aid decision making on this matter.

d) Staff Retention (Reasonable Assurance)

IV presented the report which reviewed and assessed the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.

Would exit interviews be a more appropriate method than exit questionnaires to gather information?
Why is the turnover rate in Powys higher than the Welsh average?
HB advised that the Workforce and Culture Committee on 10 December 2024 received a presentation on these matters which would be circulated to Audit, Risk and Assurance Committee members.
Action: Director of Corporate Governance

e) Capital Systems (Reasonable Assurance)

LT presented the report which focussed on the selection, appointment and contractual arrangements applied at Capital and Estates projects (covering both advisors and contracts).

Is the agreed management action in relation to Contract Completion appropriate?
LT noted this related to smaller projects (the largest being £78k) and was understood to be a communication issue rather than a control problem.

PH noted the management response had been accepted by the auditor.

f) Energy Management (Reasonable Assurance)

LT presented the report which focussed on effective management and control of energy costs given the rising costs of energy.

HT noted there had been substantial focus on this area and welcomed the improvement to date.

CR joined the meeting 11.00

g) Deprivation of Liberties Safeguards (Limited Assurance)

IV presented the report which reviewed the controls and processes in place for the control, operation and reporting of the Deprivation of Liberty Safeguards (DoLS) as operated by the Health Board.

CR welcomed the findings of the audit which were not a surprise but gave helpful external scrutiny. The Health Board is working closely with the Local

Authority with the intention of taking a business case to the Business Investments Group which is reflected in the management actions in the report. The situation was complicated by an earlier national intention to move to Liberty Protection Standards which had been withdrawn. The partners had put in place temporary arrangements to support the change, and it was now necessary to implement permanent arrangements.

Is there confidence that the issues identified as medium priority can be addressed effectively, and over what timescale?
CR acknowledged there were gaps in provision and greater resilience and sustainability was required. The team was small, and demand was exceeding capacity. The audit confirms there is risk and fragility in the service, but the team have grip and control of the issues and of what action is needed to effect improvements.

HT advised that the Executive team had identified this service as an area that would benefit from audit due to concerns and requiring an additional level of assurance. The Executive team would ensure this would be addressed as a matter of priority.

Are there gaps in the current policy which would expose the service to a greater risk of legal challenge?
CR advised that the policy does require strengthening however, the teams in the Health Board and Local Authority were working in partnership to mitigate risks.

CR left the meeting 11.10

The Committee **RECEIVED** and **NOTED** the internal audit reports including their findings

5.3 EXTERNAL AUDIT PROGRESS REPORT 2024/25 (ARA/24/068)

BH presented the Audit Progress Report which provided an update on the current and planned accounts and performance audit work presented to the Committee in January 2025.

In relation to the scope of local work 'a review of arrangements for managing agency staff', could staffing in Mental Health services be considered in addition to staffing in Community Hospitals?
BH confirmed that the scope would be discussed with the Lead Executive with the intention of including Mental Health staffing in this audit.

Attention was drawn to Audit colleagues of the contribution of Internationally Educated Nurses to the reduction in agency costs.

ET advised that plans were on track in relation to the audit of the 2024/25 Annual Accounts.

HB confirmed the draft Structured Assessment had been received and management were collating a response. This will be brought to the March meeting of the Committee and subsequently to the Board.

The Committee **RECEIVED** the report.

5.4 AUDIT REPORTS (ARA/24/069)

There were no External Audit Reports presented.

5.5 COUNTER FRAUD UPDATE (ARA/24/070)

ME presented the report advising that after proposals, to create a national counter fraud service had been considered, it had been agreed to retain local counter fraud presence but increase central support for counter fraud including in relation to education and communication from a national perspective. It was noted there are variances in the skill sets of counter fraud officers across the organisation and it was proposed to standardise job descriptions and person specifications.

ME drew attention to intelligence received in relation to fraudulent use of obesity medications either by over prescribing or diversion of prescribed medication. The team were working with Health Care colleagues in relation to prescribing and weight loss management arrangements.

Resource utilisation is showing as £225k compared to an allocation of £308k. What will happen to the unused allocation?
ME confirmed that the allocation was a full year, and the utilisation was year to date. It was expected that the full resource allocation would be used in year.

Does the Counter Fraud service get the support required from Health Board staff to fulfil their role?
ME confirmed good relationships with Health Board staff existed including with the Communications Team for engagement and promotional work.

Is Artificial Intelligence (AI) used in tackling fraud?
ME confirmed that AI is starting to be used for analytical purposes. At present it is necessary to check the outcomes, and the team are working on the basis of 'trust and verify'.

Can the resource allocation be moved between areas within Counter Fraud services?
ME confirmed there was a degree of flexibility, however, if it appeared that this flexibility might impact on the potential to deliver the work plan this would be brought the attention of the Committee.

The Committee:

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

5.6 POST PAYMENT VERIFICATION (MID YEAR REPORT) (ARA/24/071)

ST presented the mid-year report on Post Payment Verification.

How are dispensing GP practices reviewed?
ST confirmed that a new service had been introduced examining Dispensing Services separately from General Medical Services (GMS). The outcomes

from Dispensing Services reviews will be reported to the Pharmacy Team in the Health Board.

Are the numbers of revisits particularly high at present?
ST explained that post payment verification of GMS had been paused during the pandemic and whilst a new payment system was brought in. When post payment verification recommenced, there was a focus on routine visits initially and revisits were not picked up until this year which is why there appears to be a high number of revisits at present.

The Committee:
NOTED the report and took **ASSURANCE** from the information contained therein.

5.7 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/24/072)

SP presented the report advising that one Single Tender Waiver request had been made in quarter 3, which was the first request made during the financial year 2024/25.

Committee Members noted and welcomed the reduction in single tender waivers presented to the Committee.

The Committee:

- **NOTED** there had been one Single Tender Waiver request made between 1 October 2024 and 31 December 2024.
- Took **ASSURANCE** that the organisation had an appropriate system in place to capture and report single tender waivers.

5.8 RECORDS MANAGEMENT (ARA/24/073)

HB presented the report which gave an update on the records management work plan and specifically on progress since the Records Management Internal Audit of 2019. Good progress had been made; however, further work was needed, particularly in relation to records storage with a Business Case in development noting this would be restricted to the use of existing resources.

Does the Health Board have sufficient staff trained in Records Management?
HB confirmed the number of staff trained in Records Management is sufficient at present and this is kept under regular review.

The Committee:

1. **RECEIVED** the report taking **ASSURANCE** that all work has been undertaken to address all internal audit recommendations from the 2019 Audit report (which was a limited assurance rating)
2. **RECEIVED** the update report in relation to the records management work plan taking **ASSURANCE** that a robust programme of activity was in place
3. **NOTED** the work required to transition to three designated facilities which will enhance data security, streamline access and retrieval and ensure consistent compliance with regulations across all services. Further details will be provided in due course for corporate consideration.

6. ITEMS FOR DISCUSSION
There were no items for inclusion in this section
7. CONSENT AGENDA
7.1 WORK PROGRAMME (ARA/24/074)
The committee **TOOK ASSURANCE** and **NOTED** the Annual work programme. There were no amendments or questions.
8.OTHER MATTERSON
8.1 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/24/075)
The following items were agreed to be brought to the Board and other Committees: • Internal Audit reports to be provided to appropriate Committees for information • Internal Audit Report (Deprivation of Liberty Safeguards) be referred to the Patient Experience, Quality and Safety Committee to monitor progress against recommendations **Action: Director of Nursing, Quality, Women and Family Health**
8.2 ANY OTHER URGENT BUSINESS (ARA/24/076)
There was no other urgent business.
8.3 COMMITTEE FEEDBACK (ARA/24/077)
The following feedback was noted: • A focussed and purposeful meeting • The agenda was set out in a sensible, systematic way • The meeting was well chaired and finished on time • Consideration could be given to reordering Internal Audit Reports to start with the lower assurance reports to facilitate appropriate focus • The Chair facilitated appropriate time to be spent on necessary items to good effect • It will be necessary to consider the length of the March and May meetings if the expected number of finalised regulatory reports are presented.
5.5 DATE OF NEXT MEETING
The date of the next meeting is scheduled on 11 March 2025 at 10:00 via Microsoft Teams.

Meeting closed at 12:05

Audit and Risk Assurance Committee

RAG Status:

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

Audit and Risk Assurance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW- none								
OPEN ACTIONS - none								
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 11 March 2025)								
14-Jan-25	ARA/24/66	Director of Corporate Governance	Internal Audit Progress Report 2024/25	IV and HB to agree arrangments for timely release of Internal Audit Reports to ARAC Committee members	**11.03.25 update:** Agreement agreed and will be applied where appropriate (released as received) - no timnely reports for release for March meeting	Mar-25		Completed
14-Jan-25	ARA/24/67	Director of Corporate Governance	Internal Audit Report - Staff Retention	Circulation of report to Workforce and Culture Committee to ARAC Committee Members on staff retention	**11.03.25 update:** This presentation was circulated to ARAC members on 14.01.2025	Mar-25		Completed
14-Jan-25	ARA/24/75	Executive Director of Nursing, Quality, Women and Family Health	Items to be brought to the attention of Board and other Committees	Deprivation of Liberty Safeguards Internal Audit to be referred to the Patient Experience, Quality and Safety Committee to monitor progress against recommendations	**11.03.25 update:** The Internal Audit report was received at PEQS on 11.02.25 and monitoring progress against management recommendations has been added to the PEQS work programme	Mar-25		Completed
09-Jul-24	ARA/24/16	Director of Corporate Governance	Internal Audit Progress report 2024-25 and Internal Audit 2023-24	Create a procedure and decide on which Committee (ARAC or D&P) will be responsible for tracking High level Audit recommendations. Add this as an action to the Audit report.	**08.10.2024 update:** PTHB Audit handbook in development which will include this action. Initial presentation also on agenda for 08.10.24 meeting. PTHB handbook due to Committee January 2025 so action remains open. **14.01.25 update:** roles considered at the October 2024 meeting, audit handbook in development, change of date requested to March 2025 **11.03.25 update:** Audit Handbook has been developed and ison the Agenda for the March meeting for approval.	Oct-24	Mar-25	Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 5.3

Audit, Risk and Assurance Committee	**11 March 2025**
Subject:	**Draft Internal Audit Plan 2025/26**
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 present the draft Internal Audit Plan for 2025/26 to the Committee for review, comment and approval.

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

RECOMMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Approve** the Internal Audit Plan for 2025/26;
- **Approve** the Internal Audit Mandate and Charter; and
- **Note** the associated Internal Audit resource requirements and Key Performance Indicators.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

The draft Internal Audit plan for 2025/26 has been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents.

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

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

The plan covers the whole of the 2025/26 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

BACKGROUND AND ASSESSMENT:

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

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

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

The Internal Audit Mandate and Charter has been updated as at March 2025 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

NEXT STEPS:

Progress towards delivery of the Internal Audit plan will be reported to each meeting of the Committee during 2025/26.

Internal Audit Plan 2025/26

Powys Teaching Health Board

Contents

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

1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

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

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

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

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

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

2.2 Risk based internal audit planning approach

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

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

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

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

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

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

Therefore, our Plan is made up of several key components:

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

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

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

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

5) The impact of audits undertaken at other NHS Wales bodies that may impact on HEIW, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).

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

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the

Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

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

- A review of the Health Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee, the Patient Experience, Quality and Safety Committee and the Delivery and Performance Committee).
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

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

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

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

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

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

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

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

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

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

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

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

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Under the approach we have adopted for several years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the Health Board will need to pay an additional £95,131 (£106,680 in 2024/25) over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2025/26.

This additional amount is made up of two elements:

1. £59,384 (£72,635 in 2024/25) to cover work provided on all aspects of the plan other than Capital & Estates; and
2. £35,747 (£34,045 in 2024/25) for work undertaken by our Capital & Estates team as part of the overall audit plan.

Please note that for major programmes/projects where a business Case has been approved and funded by Welsh Government and where a provision is included for internal audit work, these will be facilitated through the Integrated Assurance and Approval Plan process. There are currently no further Health Board projects proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2025/26.

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

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

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

6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
1. Risk Management / Assurance Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	BAF / CRR	Corporate Governance / Board Secretary	Q4
2. Policy Management Review the arrangements and processes in place for the creation, management and review of Health Board policies.	Deferred from the 24/25 plan	Corporate Governance / Board Secretary	Q3
3. Budget Setting To review how the Health Board sets delegated budgets to meet its agreed financial plan.	CRR001 & 002 Audit being completed across a number of HBs.	Finance, Capital & Support Services	TBC
4. Core Financials Review elements of the core financial systems on a cyclical basis. Covering – GL Management / Treasury Management / Accounts Receivable / Capital Asset Management.	CRR001	Finance, Capital & Support Services	Q3
5. 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.	CRR009	Finance, Capital & Support Services	Q2/3

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
6. 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.	CRR009 £2.7m 25/26 discretionary allocation, Targeted Estates Funding (TEF) and previous WG yr-end monies.	Finance, Capital & Support Services	Q3
7. 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. *Delivered through the internal audit plan due to the omission of an integrated audit plan from the SOC/OBC submission.*	CRR009 Bid submitted to the Health & Social Care IRCF for first phase of the development.	Finance, Capital & Support Services	Q3
8. Site Co-ordination Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22. *Timing of the audit dependant on completion of the Health Board's review of arrangements.*	Deferred from the 24/25 plan	Finance, Capital & Support Services	Q4
9. Catering Services Review of processes and controls in place to ensure compliance with Environmental Health Office Standards / hygiene ratings.	Previous negative Environmental Health inspection.	Finance, Capital & Support Services	Q3
10. 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.	CRR001	Primary, Community Care & Mental Health	Q2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
11. 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.	CRR004	Primary, Community Care & Mental Health	Q1
12. Community Care Review of how different teams within the community are working together for care of the patient.	CRR008	Primary, Community Care & Mental Health	Q2
13. Primary Care Clusters - Project Management How are the project management processes working to enable implementation of developments.	CRR008	Primary, Community Care & Mental Health	Q3
14. Strategic Commissioning Review of commissioning processes with focus on developments around strategic nature of commissioning, linked to affordability for Powys. *Exact scope of audit to be agreed.*	CRR005 High level and value of commissioned services.	Planning, Performance & Commissioning	Q2
15. 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.	CRR001 & 002 Key requirement for de-escalation from targeted intervention.	People & Culture	Q3

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
16. Staff Development Programmes Review of the processes for developing and delivering staff development programmes, linked into Management Charter / Compassionate Leadership.	CRR006	People & Culture	Q2
17. Strategic Equality Plan Review of delivery against the Health Board's Anti Racism Plan.	CRR006	People & Culture	Q4
18. 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.	CRR004	Allied Health Professions, Health Sciences & Digital	Q2
19. Digital Systems Penetration Review the level of uptake and utilisation of digital systems once they have been introduced.		Allied Health Professions, Health Sciences & Digital	Q1
20. Digital Operating Model & Strategy Review of the Health Board's new Digital Operating Model following previous Section 33 arrangements being brought in-house.	CRR003	Allied Health Professions, Health Sciences & Digital	Q3
21. Follow-up: DoLS Follow-up of 2024/25 Limited assurance audit to establish progress made towards implementation of the agreed management actions.	Follow-up	Nursing, Quality, Women & Family Health	TBC

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
22. Concerns / Complaints / Putting Things Right (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.	CRR003	Nursing, Quality, Women & Family Health	Q2
23. Decontamination Review of the Health Board's structures and processes for decontamination of equipment, to ensure compliance with standards and legal requirements.	CRR004	Nursing, Quality, Women & Family Health	Q1
24. Mortality Reviews Review of processes for dealing with deaths that are referred back to the Health Board by the medical examiner for further review.	CRR004	Medical	Q3
25. Vaccine Storage Review of the processes in place for local storage of vaccines and immunisations to ensure maintenance of cold chain.	Incidents linked to fridges and school immunisations	Public Health	Q4

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	80%
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	85%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

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

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

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

2 Purpose and responsibility

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

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

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

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

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

3 Independence and Objectivity

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

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

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

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

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

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

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

4 Authority and Accountability

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

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

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

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

4.5 The Audit, Risk & Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk & Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

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

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

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

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

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

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

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

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

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk & Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

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

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

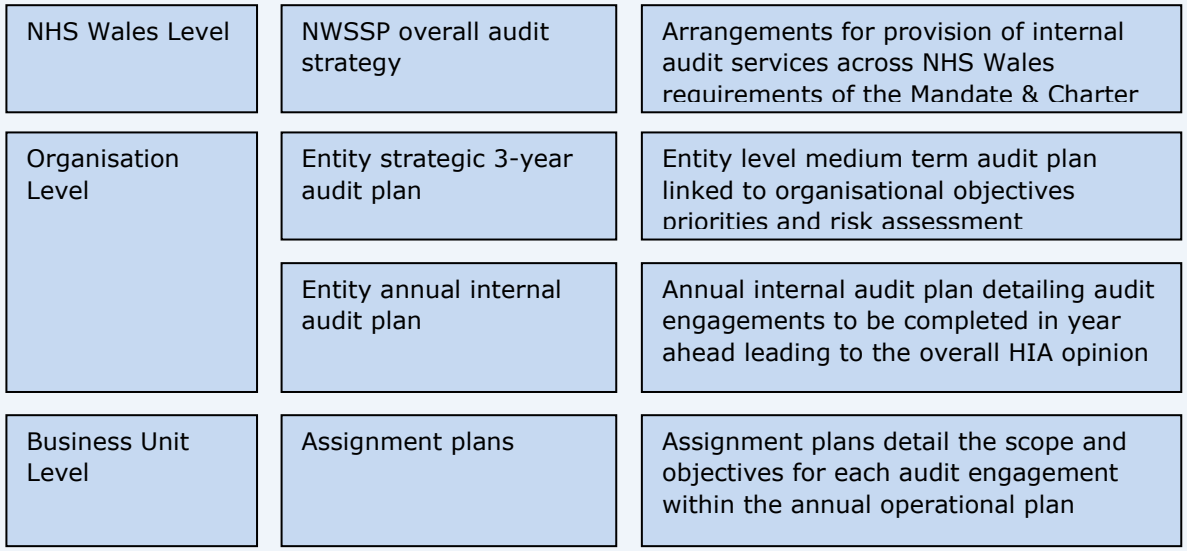
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

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

8 Approach

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

Figure 1: Audit planning hierarchy



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

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit, Risk & Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

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

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

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

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

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

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

9 Reporting

9.1 Internal Audit will report formally to the Audit, Risk & Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

b) Disclose any qualification to that opinion, together with the reasons for the qualification.

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit, Risk & Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk & Assurance Committee requirements; and
- The Audit, Risk & Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk & Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk & Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk & Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk & Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk & Assurance Committee.

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

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

10 Access and Confidentiality

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

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

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

11 Irregularities, Fraud & Corruption

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

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

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

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

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

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

13 Resolving Concerns

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

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

14 Review of the Internal Audit Mandate and Charter

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

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2025

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the 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 regarding the advice and information contained.

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

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Archwilio Cymru
Audit Wales

Powys Teaching Health Board – Detailed Audit Plan 2025

Audit year: 2024-25

Date issued: February 2025

Document reference: 4741A2025

Contents

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

Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 22) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

Assure people that public money is being managed well

Explain how that money is being spent

Inspire the public sector to improve

Our vision

Fully exploiting our unique perspective, expertise and depth of insight

Strengthening our position as an authoritative, trusted and independent voice

Increasing our visibility, influence, and relevance

Being a model organisation for the public sector in Wales and beyond

Our areas of focus

A strategic, dynamic, and high-quality audit programme

A targeted and impactful approach to communications and influencing

A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

represents 1% of gross expenditure based upon 2023-24 audited financial statements.

£4.46m

Performance materiality

represents 75% of materiality.

£3.35m

Reporting threshold (trivial)

represents 5% of materiality.

£0.22m

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report	Related party disclosures
£1,000	£5,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Failure of first financial duty

There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at January 2025 shows

a year-to-date deficit of £13.7m and a forecast year-end deficit of £15.8m. This, combined with the outturns for 2022-23 and 2023-24, predicts a three-year deficit of £34.8m.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Our planned response

My audit team will:

- continue to monitor the Health Board's financial position for 2024-25 and the cumulative three-year period to 31 March 2025;
- perform enhanced substantive testing on areas in the financial statements where transactions are at higher risk of being reported in the incorrect period; and
- consider the impact of any relevant uncorrected misstatements over the three-year period to 31 March 2025.

Risk of misclassification in capital expenditure

The January 2025 Monthly Monitoring Return data shows that the Health Board has incurred capital expenditure of £3.5m as at the end of January 2025 and have a capital resource limit and forecast capital spend of £13.5m for the year ending 31 March 2025.

In our view this presents an increased risk of misclassification of revenue expenditure as capital for in-year expenditure. Additionally, capital expenditure could be accounted for in 2024-25 for goods and services not received before the year end.

Our planned response

My audit team will:

- continue to monitor the Health Board's capital position for 2024-25;
- perform enhanced substantive testing on a sample of additions to ensure that they are appropriately classified and are reported in the correct period.

Remuneration report disclosures

There have been several new appointments to senior officer and board member posts during 2024-25 which need to be captured in the remuneration report. In recent audits this is an area where we have found errors. Consequently, we feel there is a risk that appointments will not be appropriately disclosed in the remuneration report. The remuneration report is material by nature, and there is a risk that even low value errors in the disclosures could result in a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the LHB and the other body/party.

The LHB has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, related transactions can be more difficult to identify and are more likely to not be declared. Such relationships are of high public interest and are considered to be material by their nature.

Hence, there is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions and Contingent Liabilities

The financial statements include provisions and contingent liabilities for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions and contingent liabilities.

This subjectivity and uncertainty increase the risk of material misstatement.

Our planned response

My audit team will:

- Review management's estimation process for the valuation of provisions;
- Consider the competence, capability and objectivity of the management experts who are prepare the estimates;
- Perform detailed testing on a sample of claims; and
- Ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Data Transfer to Oracle Cloud Servers

In October 2024, the Health Board's ledger data was transferred from Cardiff and Vale Health Board's data centre to Oracle data centres in Slough. There is potentially a risk of data loss occurring as part of the transfer, which could affect the integrity of the accounting records.

Our planned response

My audit team will:

- Ensure that proper practice was followed for the data transfer; and
- Review the data reconciliation work to gain assurance that the data transfer was completed successfully and that the integrity of data was maintained.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **January to February 2025**	• Information flows, • Planning meeting, • Detailed risk assessment procedures, • Fraud risk assessment, • Accounting estimates planning, • Indicative audit fee, • Draft Detailed Audit Plan.
Interim **February to April 2025**	• Ongoing risk assessment procedures, • IT risk assessment and controls review, • Develop testing strategy, • Early sample testing.
Fieldwork **May to June 2025**	• Update risk assessment, • Audit of financial statements to include narrative report and annual governance statement, • Complete audit testing, • Evaluate audit findings, • Audit closure meeting.
Reporting **June 2025**	• Audit of Accounts Report, • Recommendations for improvement, • Present findings to those charged with governance, • Auditor General certification, • Submission of accounts to Welsh Government, • Laying of accounts with Senedd Cymru, • Annual audit summary, • Post project learning.

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

- Strategic planning
- Financial planning
- Performance and risk management
- Workforce planning
- Asset management
- Collaborative working
- Overall governance.

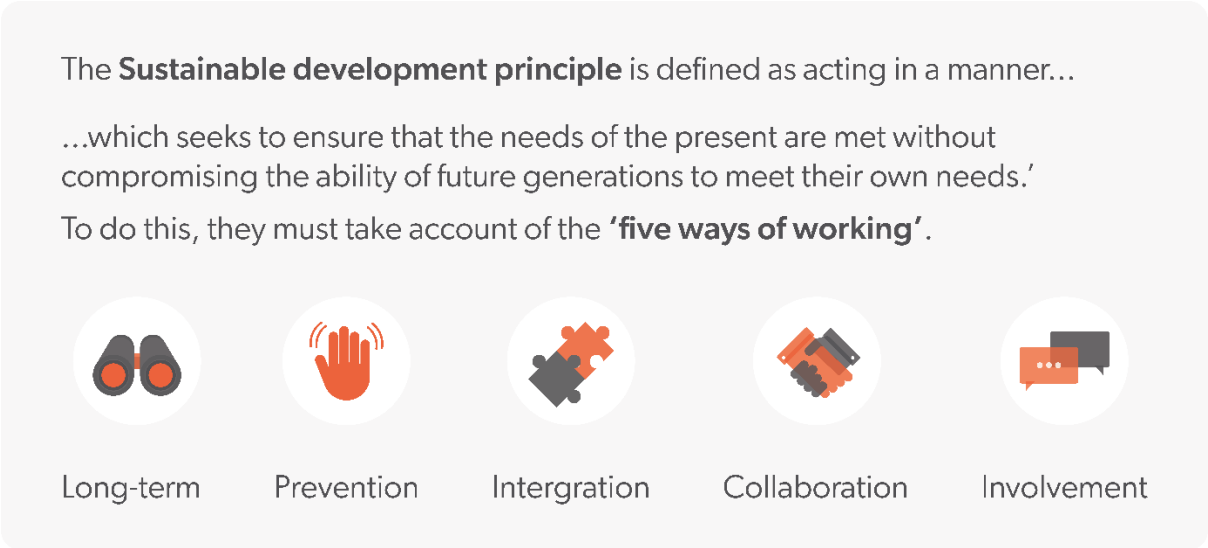
My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my performance audit work.

Structured Assessment – core

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Structured Assessment – review of the arrangements to manage estates

Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams 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.

Indicative timescales

Fieldwork to commence between April and May 2025 and reporting by the end of September 2025.

All-Wales thematic review of cancer services

Scope of the work

I plan to undertake work following on from my recent review of the national leadership arrangements for cancer services. Whilst the exact focus of this work is still 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.

Indicative timescales

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

Local project work

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. In terms of local project work, my early planning work suggests there would be value in reviewing the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the intended outcomes / benefits.

Indicative timescales

Fieldwork to commence September and October 2025 and reporting by the end of March 2026.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Your estimated total audit fee: £326,626

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance and/or the Director of Corporate Governance.

Exhibit 2 sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)

Estimated fee for 2025 (£)[1]		Estimated fee for 2024 (£)	
Audit of financial statements[2]	Performance audit work[2]	Audit of financial statements	Performance audit work
£201,851	£124,775	£198,477	£122,691
Total fee: £326,626		**Total fee: £321,168**	

[1] The fees shown in this document are exclusive of VAT.

[2] Payable November 2024 to October 2025

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Dave Thomas dave.thomas@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Lead	Gareth Lucey gareth.lucey@audit.wales	Dave Thomas dave.thomas@audit.wales
Audit Manager	Mike Jones mike.jones@audit.wales	Anne Beegan anne.beegan@audit.wales
Audit lead	Ali Tariq ali.tariq@audit.wales	Bethan Hopkins bethan.hopkins@audit.wales

I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention.

Powell, Bethan
06/03/2025 16:45:58

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

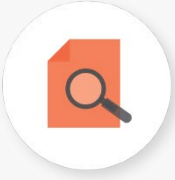
We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support



Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
Audit Wales

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E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

AUDIT, RISK AND ASSURANCE COMMITTEE	**11 MARCH 2025**
Subject:	**Annual Review of Standing Orders**
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 making of the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024.

The Health Board is required to reviews its Standing orders annually, this paper forms part of the annual review.

The Standing Orders were last reviewed in May 2024 but have also been subject to minor change in relation to the Joint Commissioning Committee in January 2025.

RECOMMENDATION(S):

The Committee is asked to

- **REVIEW** the paper and **RECOMMEND** the identified changes to the Board for approval.
- **NOTE** recommended changes to the Standing Financial Instructions and Executive Scheme of Delegation are likely to be recommended in 2025.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	

3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

REVIEW OF PTHB STANDING ORDERS

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 Orders are available using the link here - Board Approved May 2024 LHB Model Standing Orders Reservation and Delegation of Powers

Following a Welsh Government led review during 2024, following a period of engagement with NHS organisations, in January 2025, Welsh Government published the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 and the following changes are required to be made to the Health Boards Standing Orders:

Section	Description	Overview of change / recommendation
1.1.1	Membership of the Health Board	Officer Members to be 'appointed by Non-Executive Members of the Board and Chief Executive' rather than 'appointed by the Board'
1.1.3	Health Board Officer Members	Officer Members to be 'appointed in accordance with the Constitution, Membership and Procedural Regulations' rather than 'appointed by the Board'
1.1.4	Independent Members	The 'trade union official' now needs to be 'a nominated trade union official'

7.4.4	Meetings: Notifying and equipping Board Members	Agenda and supporting papers to be issued 'five clear days before a formal Board meeting' rather than '7 calendar days before a formal Board meeting'
7.4.8	Meetings: Notifying the public and others	Notification of a Board meeting is still required to be posted 10 calendar days before the meeting, but the public part of the agenda and papers supporting the public part of the agenda are no longer required to be posted 10 calendar days before the meeting (see below)
7.4.8	Meetings: Notifying the public and others	The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

Standing Financial Instructions (SFIs)
The SFIs have been reviewed and no changes are recommended at this time. It is anticipated some administration changes will be recommended during 2025/26, this is likely to include financial delegation levels of officers.

Executive Scheme of Delegation
The executive scheme of delegation was last reviewed in May 2024 when changes were made to Executive team portfolios. The scheme of delegation is currently being reviewed and it is likely some minor changes will be recommended to the Board in May 2025.

Board Committee Terms of Reference (ToRs) and Advisory Groups
The Board Committee ToRs are currently under review by each Committee, a report will be producing summarising all recommended changes and presented to the Board in May 2025.

Board Advisory groups ToRs are also under review and as above any recommended changes and presented to the Board in May 2025.

Remaining Schedules of the Standing Orders
There are no further changes recommended to the remaining components of the Standing Orders.

NEXT STEPS:

The Standing Orders and Reservation and Delegation of Powers will be amended and a revised version uploaded to the Health Boards website.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.6

AUDIT RISK & ASSURANCE COMMITTEE	**Date: 11 March 2025**
Subject:	**AUDIT PROCESS AND REPORTING HANDBOOK**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A
Appendices:	**Appendix 1-** Audit Process and Reporting Handbook

PURPOSE:

The purpose of this paper is to present the Audit, Risk and Assurance Committee with the newly developed Audit Process and Reporting Handbook for approval.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

- **APPROVE** the Audit Process and Reporting Handbook and
- **Take ASSURANCE** the organisation has a system in place to equip colleagues with the necessary information should they be involved in an audit within the Health Board, whether internal audit or external audit.

Approve/Take Assurance	Discuss	Note
Y	N	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Internal and External Audit are key components of the Health Board's financial, operational and assurance processes. They operate across the organisation. This Audit Process and Reporting Handbook is therefore relevant to all the Health Board's 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	

Powell, Bethan
06/03/2025 16:45:58

EXECUTIVE SUMMARY:
Internal and external audit are both key components of the Health Board's financial, operational and assurance processes and both play a crucial role in ensuring transparency, accountability, and good governance within the organisation. The Audit Process and Reporting Handbook has been developed to provide colleagues with useful information should they be involved in an audit and to support them through audit process, including defining roles and responsibilities of those involved, senior management and the Board's committees, a glossary of key terms and information regarding the audit tracking process. The handbook's scope does not include other forms of audit such as clinical or quality audits.
NEXT STEPS:
If approved the Corporate Governance Team will publish and distribute the handbook, ensuring that awareness is raised via the appropriate communication channels. The handbook will be reviewed after 12 months initially, and every 2 years thereafter.

AUDIT PROCESS AND REPORTING HANDBOOK MARCH 2025

Version No:	Approved by:	Date of Approval:	Date of Issue:	Review Date:
V1	Audit, Risk and Assurance Committee	TBC	TBC	March 2027

Brief Summary of Document:	This handbook is intended to equip colleagues with the knowledge you need should you be involved in an audit within the Health Board, whether that is an internal audit or external audit. It also sets out roles and responsibilities including those for senior management and the Board's Committees.
Scope:	This handbook applies to all employees of the Health Board involved in internal or external audit activities. This handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Health Board.
Owning Committee	Audit, Risk & Assurance Committee

Document Owner:	Director of Corporate Governance / Board Secretary	Document Author:	Deputy Board Secretary

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	Document established	March 2025

CONTENTS

1. Introduction

Internal audit and external audit are both important components of the Health Board's financial and operational processes, but they serve different purposes and have distinct characteristics.

All NHS Wales organisations must have an internal audit function and that is provided by NWSSP Audit and Assurance Services (herein referred to as Internal Audit). Internal audit provides independent, objective assurance and advisory activities designed to add value and improve governance and operational efficiency, risk management and control for all NHS Wales bodies.

The Auditor General for Wales is the Health Boards's external auditor[1] and staff from Audit Wales will deliver an annual programme of statutory audit work that verifies the accuracy, fairness and regularity of the financial statements for the Health Board and Powys Health Chairty. The Auditor General also has a duty to be satisfied that the Health Board has proper arrangements in place to use its resources efficiently, effectively and economically, and uses a programme of performance audit work, including an annual Structured Assessment, to discharge this duty.

Both types of audits play crucial roles in ensuring transparency, accountability, and good governance within an organization. The findings from internal audit reviews are taken into account by Audit Wales staff when conducting their audits, and likewise structured assessments and other external audit findings are relied upon by Internal Audit when conducting internal audit reviews.

This handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Health Board.

It is intended that this Handbook will be reviewed within twelve months of its approval date.

2. Why is audit important?

Regular audits are an important part of organisational learning and development. They provide valuable assurance to the Board and our key stakeholders on performance. It is important to understand that an audit is not a fault-finding exercise. Internal audits are designed to support you and your teams to identify areas of noncompliance and provide opportunities for improvement. They can be a great celebration of success, particularly where a substantial assurance rating is provided. Also, when a reasonable assurance rating is given to an audit there are often areas of excellent work recognised.

[1] 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. Audit Wales is not a legal entity and itself does not have any functions.

The annual programme of work conducted by the Auditor General provides assurance for the Board and our stakeholders on the regularity of the financial statements and the efficient, effective and economical use of resources by the Health Board. Whilst an overall rating is not provided by Audit Wales, key findings are highlighted within their reports.

The insights that audits generate provide tangible opportunities for improvement. Because they serve as an additional quality control step, you will be able to pinpoint the root causes of any operational or process issues. Knowing this, you will then be able to take your processes to the next level.

By conducting audits on a regular basis, we are demonstrating to our people, our patients and our stakeholders that Powys Teaching Health Board takes issues of quality, patient safety, health and safety, and regulatory compliance seriously.

Internal audit reports contribute to our end of year Head of Internal Audit Opinion (see section 3)

3. Internal Audit

3.1 What is an internal audit?

Internal audit is an independent assessment of a system or process through an objective examination of evidence. The aim is to give management and the Audit Committee confidence (assurance) that:

- appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and

- those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.

We have included a Glossary at **Annex 1** to aid in your interpretation of this handbook and of any internal audits you may review.

3.2 Who are internal audit and what do they do?

As set out above, the Health Boards's internal audit services are not carried out 'in house' but by the NWSSP Audit and Assurance Services. They deliver their work primarily through the following:

Annual Audit plan

Annually a plan is developed which sets out a range of internal audit reviews that will be conducted in the Health Board that financial year. The plan is aligned to the Health Board's strategic risks and is developed in conjunction with your Executive Director and following consideration of the key documents such as the Board Assurance Framework, Strategic Risk Register and Integrated Plan. In proposing areas to audit, Directorates are encouraged not to focus on areas we feel we have robust processes, but those that we believe can be improved or made more efficient. You can find the list of audits planned for each year here. Where necessary, particularly to address

emerging risks in year, the plan may be adjusted. The plan is approved by the Audit, Risk and Assurance Committee.

Individual audits and advisory reviews
Throughout the year Internal Audit undertake assurance and consultancy (or advisory) audit reviews in line with the annual audit plan. Each report aims to provide an assurance opinion (assurance report) or advice (consultancy reports) over a specific system or process.
Actions to address highlighted issues are agreed with management before being presented to the Audit, Risk and Assurance Committee.

Head of Internal Audit Opinion
The Head of Internal Audit Opinion (HoIA Opinion) is provided to the Health Board annually. It is based on the outcome of audit and consultancy work undertaken during the year and other information available to Internal Audit. The HoIA Opinion contributes to assurances available to the Board to underpin the Board's assessment of the effectiveness of governance and control. It is an integral piece of the Health Board's governance framework, providing assurance to inform the annual governance statement and identifying improvement opportunities.

3.3 Why is there a particular audit happening?

You may be wondering why a particular area or process in your Directorate is being audited. You will see above that an annual audit plan is developed so it is likely that this process or area of work was identified during the annual risk-based planning process or has become an emerging risk during the year. It may also have been specifically requested, e.g., by management, the Audit, Risk and Assurance Committee, a third party, etc.

3.4 The stages of an internal audit

There are a number of stages to an internal audit review. Before work starts on your audit be sure to understand the various roles and responsibilities and your part in it (see section 6).

We have set out below the various stages your internal audit will take. You may be involved in all or some of them.

a) Planning
Whilst the area for the audit will have been identified in the annual audit plan, the specifics of what the audit will cover will be agreed with your Executive Director at this first step in the internal audit. A meeting will take place with the internal auditor assigned to the audit, the Director and / or the lead manager responsible for the area or process, and an audit brief will then be agreed.

You should consider appointing a person as the central point of contact (POC) for the audit in your Directorate. That person should be involved at this planning stage and throughout to ensure Internal Audit have everything they need, and those that need to contribute to the process are fully informed.

b) Fieldwork

Fieldwork is the process of examining evidence to form an opinion, with respect to the area being audited, systems are designed to mitigate risks identified in the brief, and the mechanisms in place to mitigate those risks are operating effectively.

A kick off meeting will be held with Internal Audit and the Executive Director, and it is advisable to have your POC at that meeting also.

Internal Audit may request a number of documents or interviews with subject matter experts within the Health Board. Your POC should coordinate these interviews and provide internal audit with all documents they request. The POC should keep a log of documents provided.

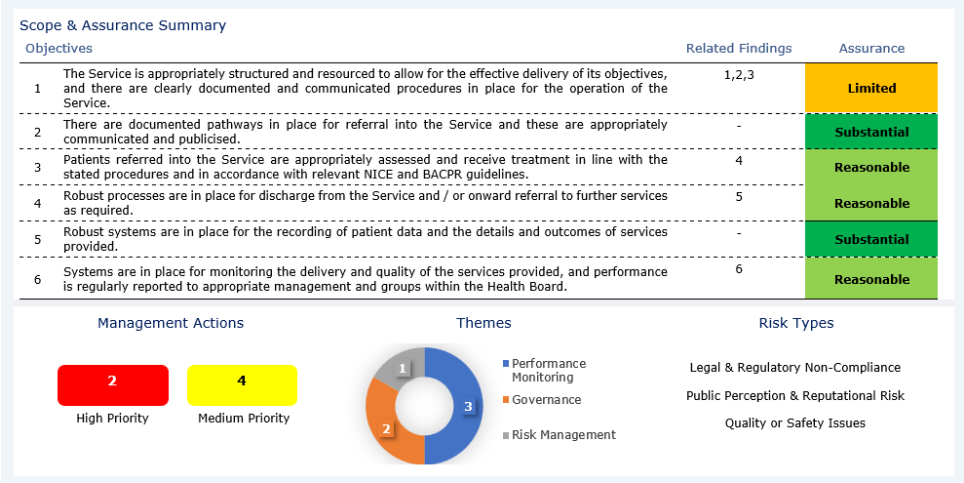
Ensure a timeframe for completion of the fieldwork is agreed. The POC will ensure they are aware of that timeframe and the date the draft report is planned to be released.

c) The Internal Audit Report (draft to final)

At the end of the fieldwork a draft report will be prepared. The Health Board has 15 working days to check the accuracy of the report and agree, or otherwise, the recommendations in the report and develop actions to address recommendations.

The report itself will set out the agreed purpose and audit objectives agreed at the planning stage. The executive summary provides a snapshot of the purpose of the audit, an overview of main issues, the overall risk rating, and a breakdown of ratings for the objectives and recommendations. It may look something like this:

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has looked at and the interviews it has conducted during the fieldwork.

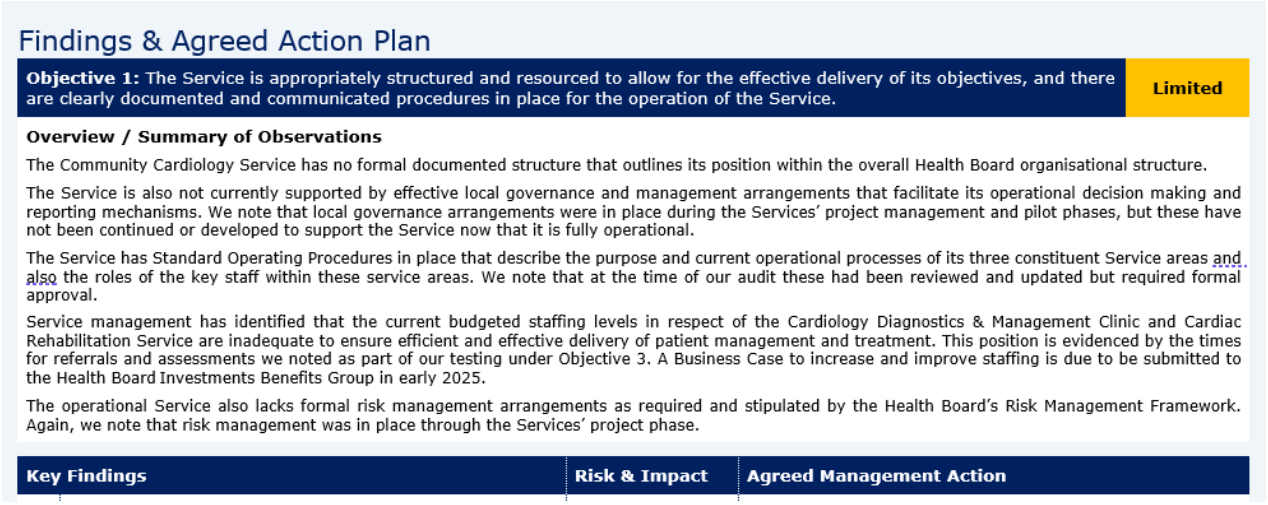


Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	1,2,3	Limited
2	There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	-	Substantial
3	Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant NICE and BACPR guidelines.	4	Reasonable
4	Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	5	Reasonable
5	Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	-	Substantial
6	Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	6	Reasonable

Annex 2 provides a detailed description of the various assurance ratings.

Issues identified and actions agreed under each objective are then summarised in the Findings and Agreed Action Plan.



Findings & Agreed Action Plan

Objective 1: The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	**Limited**

Overview / Summary of Observations

The Community Cardiology Service has no formal documented structure that outlines its position within the overall Health Board organisational structure.

The Service is also not currently supported by effective local governance and management arrangements that facilitate its operational decision making and reporting mechanisms. We note that local governance arrangements were in place during the Services' project management and pilot phases, but these have not been continued or developed to support the Service now that it is fully operational.

The Service has Standard Operating Procedures in place that describe the purpose and current operational processes of its three constituent Service areas and also the roles of the key staff within these service areas. We note that at the time of our audit these had been reviewed and updated but required formal approval.

Service management has identified that the current budgeted staffing levels in respect of the Cardiology Diagnostics & Management Clinic and Cardiac Rehabilitation Service are inadequate to ensure efficient and effective delivery of patient management and treatment. This position is evidenced by the times for referrals and assessments we noted as part of our testing under Objective 3. A Business Case to increase and improve staffing is due to be submitted to the Health Board Investments Benefits Group in early 2025.

The operational Service also lacks formal risk management arrangements as required and stipulated by the Health Board's Risk Management Framework. Again, we note that risk management was in place through the Services' project phase.

Key Findings	Risk & Impact	Agreed Management Action

Whilst the auditors will suggest a proposed management action, this will be based on the evidence provided, it may be necessary to highlight any concerns about the wording, practicality or relevance of the proposed action. This is particularly the case where the action cannot be completed fully by the Health Board and where the closing of the action would require involvement on and dependency of third parties. Third party actions may cause significant delays in closing an action, seeing an impact in any improvements, and may require escalation to the Audit Committee.

Issues are categorised according to their level of priority and the timeframe within which management actions should be completed. The prioritisation table is set out in **Annex 3.**

Each issue must be met with an agreed management action. You will have to respond with a management response within the 15 day window mentioned above.

Management actions are an important consideration and usually the last step in finalising the audit report. Often they will be obvious and likely a plan or action you already have in train or were planning. Sometimes actions will require careful planning and resourcing.

It is important to remember that the actions you promise to deliver and the dates within which you indicate they will be completed by will be monitored closely not only by your Directorate, but also by the Executive Committee and the Audit, Risk and Assurance Committee. This is primarily done via the audit tracker which is regularly reported into those forums. It is therefore crucial that management actions are:

- Approved by the Executive Director and actions assigned to suitably senior members of the team to enable them to close off actions and escalate them
- Framed in a way which broadly meets the requirements of SMART principles:
    - Specific – is there an output or a process that is required to

address the issue
- Measurable – what evidence will you be able to provide to demonstrate the action is closed
- Achievable – are there resourcing or other challenges that may prohibit the action being completed, or is a third party involvement required which may provide challenging
- Realistic – will the action address the issue, does it provide value for money and will it have the desired impact
- Timebound – do not over promise and underdeliver. Take account of pressures during the winter and annual leave, as well as the required governance routes for the action before suggesting a date by which the action will be closed off

Issues that are rated 'high' must be given priority and should where possible receive a shorter turnaround time to close the action.

Any **differences of opinion** regarding the applicability, relevance, practicality or timeliness of issues and actions should be fully discussed between auditors and the Executive Director prior to it being submitted for consideration by the Executive Committee and the Audit, Risk and Assurance and other Board Committees. If an agreed way forward cannot be found, the issue(s) should be referred to the Director of Corporate Governance/Board Secretary.

Internal audit will aim to provide the final report within ten working days of receipt of the management responses.

d) Follow Up

Internal Audit conduct a follow up audit annually to verify if agreed actions have been implemented and whether the actions taken have been effective in mitigating risk.

3.5 Reviewing and monitoring of Internal Audits

Once the internal audit report is finalised it is reviewed and discussed by the Executive Committee and the Audit, Risk and Assurance Committee. Reports relevant to Board Committees are also presented to their next meeting.

Section 6 on Roles and Responsibilities goes into more detail on the focus of these various groups.

Audit actions are transposed to the Audit Tracker. Further detail on Audit Tracker appears at section 5 below.

4. External Audit

4.1 Who is the Health Board's external auditor and what are their statutory duties and powers?

The Auditor General for Wales is the statutory external auditor of most of the Welsh public sector. This means that they audit the accounts of county and

county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies. At many of these public bodies, including the Health Board, the Auditor General also has a statutory requirement to satisfy themselves that the organisation has proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources.

The Auditor General for Wales is a crown appointment and their statutory duties and powers are contained in the following legislation:

- Government of Wales Act 1998
- Government of Wales Act 2006
- Public Audit (Wales) Act 2004
- Public Audit (Wales) Act 2013
- Well-being of Future Generations (Wales) Act 2015[2]

[2] In line with the Wellbeing of Future Generations (Wales) Act the Auditor General must carry out examinations of each named organisation's well-being objectives and the steps being taken to meet them.

Further information can be found in:

- Access rights of the AGW
- A guide to Welsh public audit legislation

4.2 What work does the Auditor General undertake at the Health Board?

To discharge their statutory duties, the Auditor General undertakes an annual programme of audit work at the Health Board, which is summarised in the Annual Audit Plan. This plan is developed following assessments of the Health Board's strategic risks, with a process similar to that described for internal audit above. The Annual Audit Plan will set out the work the Auditor General intends to undertake to audit the Health Board's accounts and undertake an independent examination of the charitable funds, as well as a programme of performance (or value for money audit work that will typically include:

- Structured Assessment work; and
- Thematic work which may examine issues specific to the Health Board or which is part of a wider examination that is also being taken forward at a number of other bodies.

The Annual Audit Plan, which also sets out the fee the Auditor General must charge for the work, is agreed by the Executive Committee and approved by the Audit, Risk and Assurance Committee.

Audited Financial Accounts

The Auditor General for Wales audits the financial statements of the Health Board annually. In addition, Audit Wales staff will undertake an independent examination of the Powys Health Charity annually. The aim of the audit is to verify that the financial statements are prepared in accordance with relevant

accounting standards and to provide reasonable assurance that they are free from material misstatements. These certified financial statements are filed with the Welsh Government (Health Board accounts) and Charities Commission (Powys Health Charity) along with the accompanying respective annual reports.

The Welsh Government Manual for Accounts guides the preparation of the Health Board's financial statements and the Finance Capital and Support Services Directorate oversees their preparation and liaises with Audit Wales throughout.

Structured Assessment
The Structured Assessment takes place annually and primarily examines corporate arrangements relating to governance, systems of assurance, planning, and financial management.

A project brief is agreed with the Executive Committee and the Board and follows similar stages to that of an internal audit above.

The Structured Assessment Report assures the Board, our people, the public and key stakeholder that the Health Board has sound corporate governance arrangements and that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

Local performance audit reviews
In addition to the Structured Assessment, the Auditor General may also review certain arrangements at the Health Board in more depth. This audit work is determined as part of the local audit planning process and is specific to the risks facing the Health Board.

All Wales thematic reviews
The Auditor General may also undertake work at the Health Board which is part of a wider thematic review examining a specific issue or service area across all NHS bodies in Wales.

National value for money examinations
In addition to the annual programme of audit work at the Health Board, the Auditor General undertakes a number national value for money examinations each year which focus on a range of topical issues, including those relevant to NHS bodies. Depending on the topic under review, national value for money examinations may involve the capture of information from the Health Board, and the published outputs from the work may include recommendations for the Health Board to respond to.

4.3 How does the Auditor General report their findings?

The findings from the audit of the accounts, the Structured Assessment and any additional performance audit reviews are set out in individual reports which are agreed with management and presented to the Audit, Risk and Assurance Committee and/or the Board. Similar to Internal Audit,

management actions will be provided to address any audit recommendations contained in the Audit General's reports and these will be monitored via the Audit Tracker.

4.4 Data Protection

During the course of the Auditor General's audit work, if any personal data is processed, such as during interviews or within Health Board documents, it is done so in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation.

5 The Audit Tracker

A tracker is maintained by the Corporate Governance Team to provide a central overview on progress against management actions on Internal Audits and Audit Wales reports. From time to time regulator reports may also be included.

Directors and the POC or action owner must ensure the actions are completed by the agreed dates. Of course, it is understandable that sometimes that is not possible and changes to agreed completion dates are warranted.
The Audit Tracker enables an Executive Director to propose changes in completion dates. This should not be required if realistic dates are provided in the original audit but where it is needed justification should be provided. The Executive Director should include in the justification the progress to date as well as any risks to a delay in completion of the action.

Any changes to dates due must be approved by the Executive Committee.

Directorates are supported to undertake regular reviews of the Audit Tracker aligned to work programme of the Audit, Risk and Assurance Committee. The Audit Tracker must be updated by the Executive Director or Action Owner when requested, ensuring:

- Where an action is proposed for closure evidence demonstrating that is provided, signposted or confirmed as available locally;
- Early warning of any actions not yet due but which may be at risk of delay
- Where a date change is required an update is required including the rationale and progress made since the date of the last review, obstacles to further progress and confirmation, or otherwise, that the revised date is achievable.

Where it is no longer possible to complete the action the Director of Corporate Governance/Board Secretary can support the Directorate to propose closure to the Audit, Risk and Assurance Committee and internal/external audit colleagues.

Where the implementation of a 'high risk' action is delayed beyond 6 months of the originally agreed date the responsible Executive Lead may be invited to attend the next meeting of the Audit, Risk and Assurance Committee to discuss the various issues involved.

Once all actions have been implemented they will be classified as complete, departments are asked to maintain records or evidence in relation to the completion of management actions as this may be requested at a later date.

6 Roles and Responsibilities

6.1 Executive Director

- Agree the internal audit brief;
- Agree recommendations / identified issues and develop management responses;
- Ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- Support and empower your team to provide all requested audit evidence in a timely manner;
- Agree a directorate process to track management actions;
- Oversee the implementation of agreed actions;
- Attend the Audit, Risk and Assurance Committee to provide assurance to members relating to an unsatisfactory or limited assurance internal audit report;
- Lead a discussion of their audit report in the Board Committees where the subject of the audit is in the remit of that Committee; and
- Ensure reviews of the audit tracker are undertaken as requested by the Corporate Governance Team.

6.2 Point of Contact (may be action owner or business manager in directorate)

- Communicate any issues to auditors which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc;
- Provide auditors with the contact details for everyone involved in the system/process being audited, even if from a different team or division; and
- Update the audit tracker when requested.

6.3 Audit Interviewees

- Cooperate and be open and honest with the audit team
- Clearly explain the process and/or system being audited providing any evidence such as meeting minutes etc as may give wider context;
- Provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner;
- Communicate challenges in providing information and/or pressures within the point of contact in your directorate; and
- Answer to the best of your ability – Auditors know that people can be nervous, and sometimes will forget the answer to a question. It is acceptable to say: "I forget that right now, but here is where I can find that information," and then to show the auditor the procedure or other information they need. If an employee doesn't know an answer, it is far worse to make up the answer than to just say, "I don't know, but I can find out."

6.4 Director of Corporate Governance/Board Secretary

- Ensure there is an adequate provision of internal and external audit services;
- Coordinate the development and approval of the annual audit plan
- Coordinate reporting of final audit reports to Executive Committee, Audit, Risk and Assurance and other relevant Committees;
- Maintenance of the audit tracker;
- Coordinate audit tracker reviews;
- Prepare progress and tracker reports to Executive Committee, Audit, Risk and Assurance Committee and Board Committees;
- Facilitate escalations from Internal Audit or on tracker; and
- Lodge quarterly Welsh Government return of audits.

6.5 Audit, Risk and Assurance Committee

- Facilitate direct and unrestricted access for the Head of Internal Audit and Auditor General for Wales to the Board;
- Review and recommend Internal Audit Charter for approval by Board;
- Receives the Internal Audit confirmation of independence annually;
- Receives regular reports from Audit Wales and Head of Internal Audit on its activities;
- Agree annual Internal Audit plan;
- Review internal audit reports, Structured Assessments and other Audit Wales reports, and scrutinise of the adequacy of management actions in response to recommendations / identified issues;
- Receive and scrutinise Audit Tracker update reports;
- Scrutinise the progress of audits overall, escalating to the Board any issues of concern; and
- Receive and review Head of Internal Audit Opinion.

6.6 Board Committees

- Receive audits in their remit;
- Monitor management actions to address recommendations / identified issues; and
- Scrutinise impact of actions in response to audit recommendations / identified issues in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

6.7 Executive Committee

- Develop proposal for annual Internal Audit plan;
- Review Structured Assessment briefs;
- Receive and review all final Internal Audit reports, Structured Assessment and Audit Wales reports;
- Receive and scrutinise Audit Tracker update reports
- Oversight of the audit framework; and
- Receive and review Head of Internal Audit Opinion.

6.8 Internal Audit

- Provide independent assurance that an organisation's risk

management, governance and internal control processes are operating effectively;
- Provide annual Head of Internal Audit Opinion to Audit, Risk and Assurance Committee;
- Provide regular reports on progress to Audit, Risk and Assurance Committee;
- Present annual Internal Audit plan;
- Present finalised Internal Audit reports to Audit, Risk and Assurance Committee;
- Review Audit Tracker and raise concerns to Director of Corporate Governance/Board Secretary and/or Audit, Risk and Assurance Committee; and
- Agree timeframes for the various stages of internal audit work with the Director of Corporate Governance/Board Secretary.

6.9 External Audit

- Provide independent assurance on the financial statements and the corporate arrangements for securing economy, efficiency and effectiveness in the Health Board's use of resource.
- Agree the briefs for audit work with the Director of Corporate Governance/Board Secretary and/or relevant Executive Director
- Provide regular reports on progress to Audit, Risk and Assurance Committee;
- Present annual Audit plan to Audit, Risk and Assurance Committee;
- Present finalised Audit reports, including the Annual Audit Report to Audit, Risk and Assurance Committee (or other Committees or the Board by agreement);
- Review tracker and raise concerns to Director of Corporate Governance/Board Secretary and/or Audit, Risk and Assurance Committee; and
- Agree timeframes for the various stages of performance audit work with the Director of Corporate Governance/Board Secretary and for the audit of the financial statements with the Executive Director of Finance, Capital and Support Services.

7 Annexures

Annex 1 – Glossary
Annex 2 – Internal Audit Assurance Ratings
Annex 3 – Internal Audit Recommendation Prioritisations

8 Annex 1 – Glossary

Glossary of terms	
Term	**Definition**
Assurance	From an internal audit perspective, this means providing an independent assessment of a system of process through an objective examination of evidence.
Audit Brief	Documentation that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics., including the audit team, key contacts and timeframes.
Audit Report	Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.
Governance	The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement of objectives.
Executive Lead	Individual within the organisation identified as the lead for the audit, usually a director. Responsibilities include: • Agreeing the audit brief; • Providing management responses to recommendations; • Overseeing the implementation of agreed actions.
Risk Management	A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.
Audit meetings	Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc. Kick-off meeting: usually held at the beginning of the fieldwork phase, audit use this meeting to get a detailed understanding of the system under review. Debrief meeting: at the end of the audit, a meeting will be held with key individuals to debrief on findings.
Control	Any measures put in place by management, the Board or other partied to manage risk and increase the likelihood that organisational goals and objectives will be achieved.
Assurance opinion	The auditors overall view of whether, for the system being audited: • The controls have been adequately designed to mitigate identified risk' and • The controls are operating effectively (i.e., are being adhered to in practice) Assurance opinions are defined in **Annex 2.**
Recommendations	Recommendations may support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system.

	Alternately, recommendations may relate to non-compliances within the system e.g., policies and procedures have not been followed.

9 Annex 2 – Internal Audit Assurance Ratings

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.

10 Annex 3 – Internal Audit Prioritisation of Findings

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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.7

AUDIT, RISK & ASSURANCE COMMITTEE	**Date: 11 March 2025**
Subject:	**Risk Management Framework**
Approved and presented by:	Helen Bushell, Director of Corporate Governance & Board Secretary
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Risk and Assurance Group – 11 February 2025 Executive Committee – 5 March 2025 – who recommend the Framework to the Committee.

PURPOSE:

To provide the Audit, Risk and Assurance Committee with the revised Risk Management Framework for endorsement ahead of presentation to the Board on 26 March 2025 for approval.

RECOMMENDATION(S):

The Executive Committee is asked to:

- **ENDORSE** the revised Risk Management Framework, for onwards presentation 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	Y	The effective management of risk is a key enabler of the achievement of the Health Board's 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	

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EXECUTIVE SUMMARY:

The Risk Management Framework sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

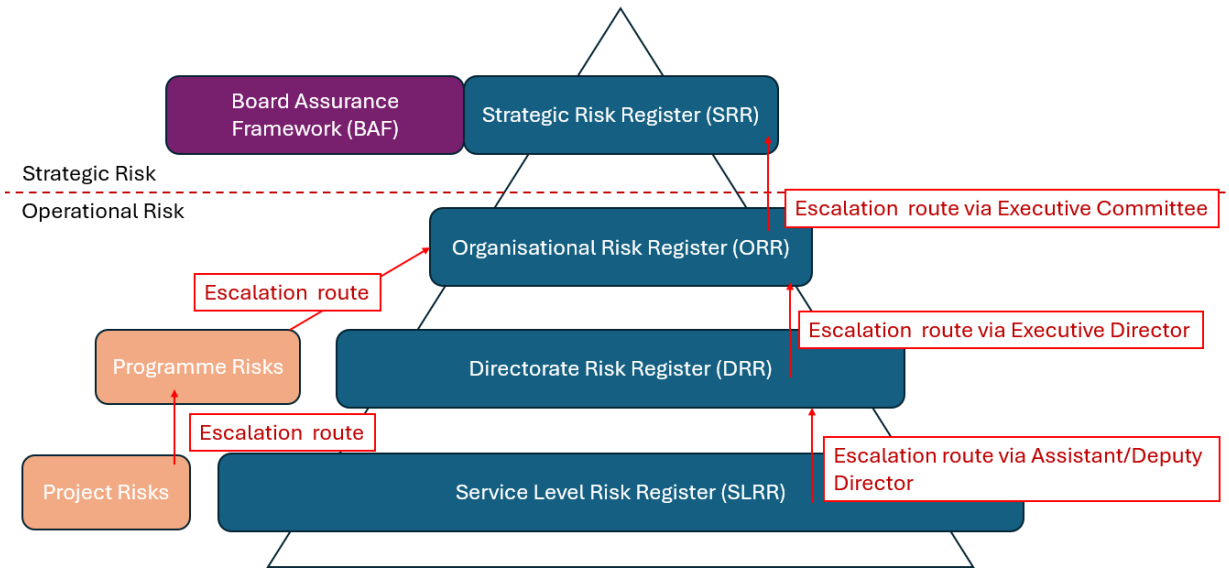
The revised RMF proposes the first material changes to the structure deployed to manage risk since 2019. The key fundamental change proposed is the closure of the current Corporate Risk Register, to be replaced with a Strategic Risk Register, owned by the Board and an Organisational Risk Register, focused on significant and cross-organisation operational risk, owned by the Executive Committee. Both registers will be co-ordinated by the Corporate Governance Team.

This creation of an additional risk register focused on significant operational rusk will allow greater focus on the risks to Health Board's strategic objectives at Board level, as well as more dynamic escalation, oversight and management of significant, cross-organisational operational risks by the Executive Team.

If endorsed the Strategic Risk Register will be developed over the coming weeks, to allow for an outline position to be reported to the Board on 26 March 2025 alongside the Integrated Plan. This outline position will then be further developed to provide a full Strategic Risk Register to the Board on 21 May 2025.

The system of Directorate and Service Level Risk Registers will remain unchanged.

A schematic of the proposed structure is included below:



It is recognised that an effective programme of training and support will be essential the effective implementation of the revised framework. Implementation will be supported by a suite of training, guidance and support which is currently under development by the Corporate Governance Team. This will include a revised Risk Management Toolkit, which will return to the Audit, Risk and Assurance Committee on 8 July 2025 for approval.

The framework also recognises that 2025-26 will be a transitionary year in regard to Health Board's risk management arrangements as a result of the transition to the Datix Cloud system as the mechanism for managing operational risk registers within the organisation, and the further work due to be undertaken to develop our approach to risk management in partnership and ensure the integration with the development of our Partnership Governance Framework.

The framework has also been updated to:

- clarify processes in relation to escalation and de-escalation;
- ensure currency with revised organisational structures, systems and processes; and
- align with established risk management guidance and best practice.

NEXT STEPS:

If endorsed the Strategic Risk Register will be developed over the coming weeks, to allow for an outline position to be reported to the Board on 26 March 2025 alongside the Integrated Plan. This outline position will then be further developed to provide a full Strategic Risk Register to the Board on 21 May 2025. The Organisation Risk Register will be developed throughout Q1 of 2025/26 and a reporting schedule into Executive Committee will be agreed.

Following approval by the Board, the Corporate Governance Team will also:

- Promote the revised RMF via the appropriate channels;
- Refresh the Risk Management Toolkit to reflect the changes to the RMF, for presentation to the Audit, Risk and Assurance Committee on 8 July 2025;
- Continue to support the implementation of the Datix Cloud Risk Management Module to enable a 'go live' of the system by September 2025;
- Develop and deliver a programme of Risk Management Training to support both the refreshed RMF and Toolkit and the transition to Datix Cloud;
- Develop the Board Assurance Framework alongside the Strategic Risk Register;
- Review the Risk Management Framework in November 2025, and every 2 years thereafter.

APPENDICES

a. PTHB Risk Management Framework

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		Effective management of risk enables proactive and preventative use of actions and mitigations to reduce undesired effects and promote a culture continuous improvement.
Timely			X		
Effective			X		
Efficient			X		
Equitable					
Person Centred			X		
Workforce			X		
Leadership			X		
Culture					
Information			X		
Learn, Improve, Research			X		
Whole Systems Approach			x		

EQUALITY:

	No impact	Negative	Positive	Both	
Age	X				There are no identified impacts on equality.
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				The Risk Management Framework sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.
Financial	x				
Corporate	X				
Operational	X				
Reputational	X				

RISK MANAGEMENT FRAMEWORK MARCH 2025

Document Number:	CGP005	Classification	Corporate

Version No:	Approved by:	Date of Approval:	Date of Issue:	Review Date:
V5.0	Board	TBC	TBC	March 2025

Brief Summary of Document:	This document aims to set out the organisational arrangements for developing and embedding risk management processes in Powys Teaching Health Board.
Scope:	This framework applies to all employees of the Health Board; Board members; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.
To be read in conjunction with:	• PTHB Board Assurance Framework • PTHB Strategic Commissioning Framework and Commissioning Assurance Framework
Owning Committee	Audit, Risk & Assurance Committee

Document Owner:	Director of Corporate Governance / Board Secretary	Document Author:	Deputy Board Secretary

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
2.2	2017 Version Updated to reflect changes in risk management arrangements and organisational realignment	September 2019
3.0	2019 Version Updated to reflect changes in risk management arrangements and organisational realignment	November 2021
4.0	2021 Version Updated to reflect changes in risk management arrangements and organisational realignment	November 2022
5.0	2022 version updated to reflect changes in risk management arrangements and organisational realignment	March 2025

Glossary of terms	
Term	**Definition**
Risk	The effect of uncertainty on objectives. An effect may be positive, negative, or a deviation from the expected. In addition, a risk is often described as an event; a change in circumstance; or a consequence.
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks, with a view to increasing the probability of success and reducing the likelihood of failure.
Risk management framework	Organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation.
Risk architecture	Risk architecture is the organisational arrangements for risk management detailing the roles, responsibilities and the lines of communication for reporting on risk management.
Risk assessment	A systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk treatment	The development, selection and implementation of risk treatment strategies and controls.
Risk appetite	The amount of risk that an organisation is willing to pursue in order to meet its strategic objectives.
Risk tolerance	Whilst risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can actually cope with.
Risk owner	The person with the authority and accountability to make the decision to treat, or not to treat the risk.
Strategic risks	Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence.

Operational risks	Risks that are by-products of the day-to-day running of the Health Board and may include risks such as to the achievement of directorate or service objectives; the day-to-day operation of the directorate or service, i.e. delivering a safe and sustainable service for patients; and risks in regard to any legislation or standards that the directorate or service should be compliant with.

CONTENTS

1. The Board's Statement

The Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board's governance framework and system of internal controls.

The Board is committed to having a risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is compliant with legal and regulatory requirements; meeting objectives; and, promoting its values.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's Appetite for Risk (see Risk Appetite Statement at Appendix A);
- Adopting an integrated approach to risk management that includes risks related to clinical care, professional standards, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is **everyone's** business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and appropriately managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses that is used for organisation-wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and
- Providing appropriate training to staff to ensure effective implementation of risk management arrangements.

2. Purpose of the Risk Management Framework

This document sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

The Framework seeks to ensure:

- that risk management is an integral element of the Health Board's culture;
- that the Health Board's risks in relation to the delivery of services

(provided and commissioned) and care to patients are minimised through effective risk management practices;
- that the wellbeing of patients, staff and visitors is optimised;
- that the resources of the Health Board are protected;
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation;
- that the Board receives adequate assurance to ensure that strategic and operational risks are being managed effectively; and
- clarity in regard to respective responsibilities for strategic and operational risk management for the Board, Board Committees, relevant groups and staff throughout the organisation.

Should you have any queries in relation to this framework or an associated document please contact:

powysdirectorate.corporategovernance@wales.nhs.uk

3. Scope of the Risk Management Framework

This framework applies to all employees of the Health Board; Board members; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services.

Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

4. The Board's Appetite for Risk

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk.

The Board is not open to risks that materially impact on the quality, safety or access to, services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which the Health Board operates.

The Board has greatest appetite to pursue innovation, and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Board's Risk Appetite Statement, which is included at Appendix A, has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas. Our risk tolerance may be cautious, in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives. The Health Board will always aim to operate organisational activities within the levels defined within the Risk Appetite Statement. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

5. The Risk Management Process

Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

The Orange Book (2023)

1. Risk Identification and Assessment

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care.

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

2. Treatment

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a risk register, which is a formal record of the risks that the Health Board has identified.

3. Monitoring

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

4. Reporting

Risk reporting supports the organisation to assess whether decisions are being made within its risk appetite to successfully achieve objectives, to review the adequacy and effectiveness of internal controls, and to decide whether any changes are required to re-assess strategy and objectives, revisit or change policies, reprioritise resources, improve controls, and/or reconsider their risk appetite/tolerance.

The Health Board's detailed guidance in support of the risk management process is included in the risk management toolkit on the staff intranet and includes guidance on how to identify, assess, treat and monitor risks. The toolkit is due to be reviewed over the course of 2025-26 to align to revised Risk Management Framework.

6. Levels of Risk

The Risk Management Framework defines three levels of risk:

1. **Strategic Risks** – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks are recorded in the Board's Strategic Risk Register (SRR). The SRR provides an organisation-wide summary of significant risks that have the potential to hinder achievement of one or more of the Health Board's strategic objectives. Strategic Risks are owned by the Board, and are reviewed and monitored by the Executive Committee
2. **Operational Risks** – Risks that represent a threat the day-to-day activities of the Health Board. Operational risk registers may include risks such as to the achievement of directorate or service objectives; the day-to-day operation of the directorate or service, i.e., delivering a safe and sustainable service for patients; and risks in regard to any legislation or standards that the directorate or service should be compliant with.

The Health Board is currently in a period of transition, with the adoption of the Datix Cloud Risk Module as our system for recording, and reporting on operational risks due to be completed in 2025/26.

There are three levels of operational risk register within the organisation:

- Organisational
- Directorate
- Service Level

3. **Project/Programme Risks** – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

Powys Teaching Health Board is predominantly a commissioning organisation, buying services on behalf of the population from a wide range of providers including primary care contractors; independent sector care homes; ambulance services; district general hospitals; and other specialist hospitals. The Health Board's **Integrated Performance and Quality Framework** helps to identify and escalate and mitigate emerging patterns of poor performance and risk in health services used by Powys patients. Through this process, risks may be identified for recording in local or directorate risk registers or the Organisational Risk Register, dependent upon the level and type of risk.

7. Risk Architecture and Escalation

Risk architecture is the organisational arrangements for risk management detailing the roles, responsibilities and the lines of communication for reporting on risk management. A risk register provides an agreed, standardised approach to recording of the significant risks that have been identified through the risk assessment process, ownership of those risks, and will also serve as a record of the control activities that are currently undertaken to manage or mitigate the risk. It will also provide a record of the additional actions that are proposed to improve 'control' of risks (i.e., to treat the risk further), including responsibility and timescales for implementation. Effectively used, a risk register will not only drive risk management but should be used to inform decision-making processes. Risk registers are also used to provide assurance that risks are being managed appropriately and effectively.

Fundamentals of Risk Management (2020)

<u>Recording of Strategic Risk</u>

Strategic risks are recorded in the Board's Strategic Risk Register (SRR). The SRR provides an organisation-wide summary of significant risks that have the potential to hinder achievement of one or more of the Health Board's strategic objectives.

The risks contained in the SRR are further scrutinised within the Health Board's Board Assurance Framework (BAF). The Board Assurance Framework provides a structure and process that enables the Health Board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic objectives. The BAF is more than a risk register as it provides assurance on the effectiveness and adequacy of the controls in place to manage the Health Board's Strategic Risks. It should support effective decision-making and inform Board agendas in addition to providing assurance on the system of internal control. It also ensures that the assurance mechanisms operating across the Health Board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives. Further detail can be found in the Board Assurance Framework.

The SRR (alongside a high-level Board Assurance Framework dashboard) is reviewed by the Executive Committee in advance of presentation to the Board at each of its meetings. The Executive Committee is responsible for recommending risks for escalation to / de-escalation from the SRR for approval by the Board. The Executive Committee may also recommend to the Board the 'acceptance' of risks that cannot be brought within the Board's risk appetite/tolerance.

Each strategic risk is allocated to a Committee of the Board for additional scrutiny and oversight. Committee Risk Registers based on the most recent iteration of the SRR approved by the Board will be reported to each Committee as a standing item.

The detailed Board Assurance Framework will be reviewed by the Executive Committee in advance of presentation to the Board on a twice-yearly basis.

Recording of Operational Risk

The Health Board is currently in a period of transition, with the adoption of the Datix Cloud Risk Module as our system for recording and reporting on the risk management process due to be completed in 2025/26.

There are three levels of operational risk register within the Health Board:

Organisational Risk Register (ORR)

The Organisational Risk Register is a log of significant risks to the organisation that have been identified from a top-down and bottom-up approach (for example these may be identified by the Board or an individual Executive Director or escalated through the organisation's risk architecture).

These are significant risks that affect the organisation's ability to achieve organisational/directorate objectives and significant operational risks affecting the delivery of healthcare services. Individual Executive Directors are responsible for identifying risks potentially requiring escalation from Directorate Level to the ORR. Whilst the Executive Committee is responsible for approving risks proposed for escalation to the SRR and subsequent de-escalation/closure of risks on the ORR.

Whilst each Director will be responsible for the ownership of their respective risk(s) and identifying current controls and developing action plans, it will be the role of the Executive Committee to review controls and ensure appropriate action plans are in place, which might include the development and agreement of corporate risk management strategies to manage risk(s). The Organisational Risk Register will be reported to the Board as an appendix to the detailed BAF.

It will be the role of the Executive Committee to report by exception any risks on the ORR which require sightedness and/or additional scrutiny by the Board or Board Committees. The primary mechanism for reporting matters pertaining to risks to the Board will be the Risk Management and Board Assurance Framework report provided to each Board meeting by the Director of Corporate Governance, though information in regard to operational risks may also be included in individual papers and Committee Chairs Assurance Reports.

Directorate Risk Registers (DRR)

Directorate level risks are any risks that affect the directorate and its objectives, or risks that have been escalated from service level.

The relevant Executive Director is responsible for approving the inclusion and closure of risks on directorate risk registers and de-escalation to the Service Level Risk Register (SLRR). Executive Directors may also highlight risks for possible escalation to ORR or request for acceptance of risk above

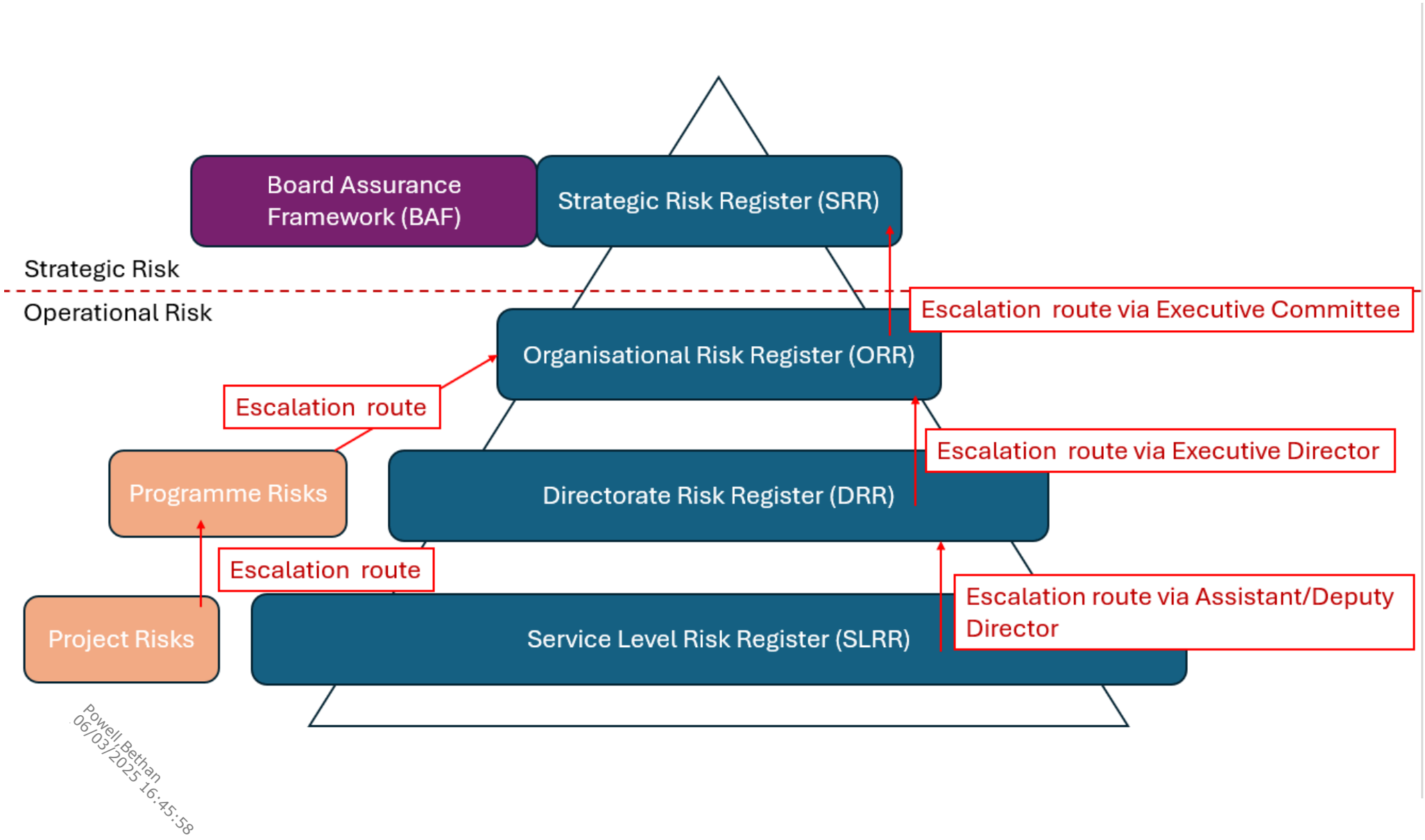
appetite/tolerance.

Each Executive Director is responsible for identifying a 'Risk Champion' within their relevant directorate to attend the Risk and Assurance Group, a sub-group of the Executive Committee. The Risk and Assurance Group (RAG) provides the opportunity to collectively review DRRs, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate.

Whilst recognising that the primary mechanism for the escalation of risk is through management channels, as part of the ORR process managed by the Corporate Governance Team the RAG may identify risks for consideration for escalation and de-escalation from/to the ORR and make a recommendation to the Executive Committee as appropriate.

Service Level Risk Registers (SLRR)
Service level risks are risks which affect a service; the Deputy/Assistant Director/Head of Service is responsible for approving the inclusion and closure of operational risks on to the service risk register, as well as highlighting risks to the relevant Executive Director for possible escalation.
The relevant Executive Director is responsible for approving service level risks that require escalation to directorate level.

The risk architecture used in the Health Board and the relationship between strategic and operational risk registers is provided below:


Board Assurance Framework (BAF)
Strategic Risk Register (SRR)
Strategic Risk
Operational Risk
Escalation route via Executive Committee
Organisational Risk Register (ORR)
Escalation route
Programme Risks
Directorate Risk Register (DRR)
Escalation route via Executive Director
Escalation route
Project Risks
Service Level Risk Register (SLRR)
Escalation route via Assistant/Deputy Director
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06/03/2025 16:45:58

8. Risk Escalation

8.1 Escalation

The risk management system includes the opportunity for escalation through the levels of the organisation's risk architecture as outlined above. Risks should be managed by the identified owner, or a person otherwise appointed by the risk owner. There may however, be circumstances where the ability to manage a risk may exceed the authority of the risk owner.

Where significant risks have been identified which are deemed too challenging to manage, consideration should be given for the escalation of these risks to the next level of responsibility for additional consideration. These could include decisions for additional resources, increased oversight, review or the acceptance of the risk. Escalation also allows the opportunity for a risk to be considered against other risks at that level in terms of its potential individual and cumulative impact(s) e.g. organisation/directorate wide perspective. This allows for a higher level of authorisation to sanction continued tolerance or undertake additional actions to manage increasingly higher levels of risk.

8.2 Potential reasons for escalation

- A risk is above appetite level and there is nothing that the risk owner can do to reduce it to within appetite
- Risk treatments are outside of the delegation of the risk owner
- A risk is shared by other areas of the organisation and risk treatment cannot be agreed
- Significant threat to patient safety, the achievement of the Health Board's plans, targets or the Health Board's reputation
- A risk is assessed to be of significant concern (for example a risk score of 20+ at Directorate Level or 16+ at Service Level)

To enable dynamic escalation and empowerment of risk owners and managers there are no minimum scoring requirements for escalation. Some risk owners may however find scoring useful as a guide when considering whether to escalate a risk.

8.3 De-escalation

Risks can be de-escalated when the higher-level risk register owner is satisfied with the management of the risk, e.g. the risk has been reduced or the risk has been accepted above appetite and there is no further benefit of higher-level oversight

9. Accountabilities and Responsibilities

9.1 The Board

The Board (Executive Directors and Independent Members) have collective responsibility for the setting and ensuring delivery of strategic objectives. Key strategic risks are identified and monitored by the Board. The BAF and SRR provide a central record of risks to the delivery of its strategic objectives. It is the duty of the Board to discuss and advise on the format and content of the BAF. It is also the duty of the Board to appropriately monitor Powys THB's significant risks, associated controls and assurances.

The Board is also responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driving the delivery of the Health Board's strategic objectives.

The workplans for the Board and each of its committees will be aligned to the BAF and SRR, ensuring appropriate focus on areas of risk.

In the context of this Framework the Board will:

- demonstrate its continuing commitment to risk management through the endorsement of this Framework;
- ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
- take a lead role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
- oversee and participate in the risk assurance process;
- ensure communication with partner organisations on problems of mutual concern including risks;
- ensure that appropriate structures are in place to implement effective risk management;
- commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
- ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data; and
- receive reports from the committees of the Board in line with terms of reference and workplans of those committees.

The Terms of Reference for the committees that report to the Board are included on the Health Board's website:
Powys Teaching Health Board Committees - Powys Teaching Health Board (nhs.wales)

9.2 Individual Responsibilities

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework.

The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

Chief Executive Officer (CEO)

The CEO is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and governance. The CEO has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Director of Corporate Governance / Board Secretary

The Director of Corporate Governance / Board Secretary is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated Board Assurance Framework and Risk Management Framework. The Director of Corporate Governance/Board Secretary will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and, Executive Directors, to oversee an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;
- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Strategic, Organisational and Directorate level risk registers;
- oversee the effective execution of the Health Board's Assurance Framework and Risk Management Framework; and
- produce the Health Board's Annual Governance Statement.

Deputy Board Secretary

The Deputy Board Secretary is accountable to the Director of Corporate Governance / Board Secretary, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the Health Board, which link to the Health Board's Assurance Framework;
- develop and implement the Health Board's Assurance Framework;
- develop and implement the Health Board's Risk Management Framework; and
- lead the development of, and Chair, the Risk and Assurance Group (established by the Executive Committee).

Corporate Governance Team

The Corporate Governance Team is accountable to the Deputy Board Secretary, and in relation to risk management will specifically:

- support the management and development of the Health Board's Assurance Framework and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Strategic Risk Register and Board Assurance Framework, for Executive Committee and Board;
- support the development and functioning of the Risk and Assurance Group;
- engage with Directorates to enable effective implementation of the Risk Management Framework and associated processes;
- and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers.

Executive Directors

Executive Directors are accountable and responsible for ensuring that their respective directorates are implementing this Framework, and related policies/procedures. Each Director is accountable for the delivery of their particular area of responsibility, and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

Specifically, they will:

- lead the embedding of an effective risk management culture throughout the Health Board;
- communicate to their directorate, the Board's strategic objectives; and ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a mechanism for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;

- co-ordinate the risk management processes which include risk assessments; incident reporting; the investigation of incidents/near misses; and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- Identify and manage risks that cut across delivery areas;
- Communicate downwards what the Health Board's strategic risks are;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, **Clinical Executive Directors** (Executive Medical Director, Executive Director of Nursing, Quality, Women and Family Health, Executive Director of Allied Health Professions, Health Science and Digital, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this framework.

Independent Members

Independent Members have an important role in risk management. This role is restricted to seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to Executive Directors and senior management. The role of Independent Members is not to manage individual risks, but to understand and question risk on an informed and ongoing basis.

Additionally, Independent Members chair Board level committees, and in line with the relevant committee Terms of Reference, should provide assurance to the Board that risks within its remit (determined by the SRR and BAF), are being managed effectively by the risk owners, and report any areas of concern to the Board.

Clinical Directors, Deputy/Assistant Directors and Heads of Service

Clinical Directors, Deputy/Assistant Directors and Heads of Service are responsible for implementation of the Risk Management Framework and relevant policies and procedures, which support the Health Board's risk management approach.

As Senior Managers of the organisation, Clinical Directors, Deputy/Assistant Directors and Heads of Service take the lead on risk management and set an example through visible leadership of their staff. These responsibilities

include:

- Taking responsibility for managing risk;
- Maintaining a Service Level Risk Register for their area of responsibility;
- Ensuring that risks are assessed where they are:
    - Identified within the working activities carried out within their management control or area of professional oversight;
    - Identified within the environment within their control;
    - Reported from the staff within their management control, or area of professional oversight.
- Identifying and managing risks that cut across delivery areas;
- Ensuring all incidents/accidents and near misses are reported;
- Monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- Discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach;
- Ensuring risks are updated regularly and acted upon;
- Communicating downwards what the Health Board's strategic risks are;
- Using the risk management process to support prioritisation and decision making;
- Ensuring staff are suitably trained in risk management;
- Promoting a risk aware culture in which staff are encouraged to identify and escalate risk;
- Ensuring that risk management is included in appraisals and development plans where appropriate;
- Ensuring the adoption and operation of the risk management framework across their work area.
- Escalating risks for further consideration where the ability to manage a risk exceeds the authority of the individual or the Board's risk appetite.

Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks within a structured risk management framework. Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers play an important role in managing and escalating operational risks and as such, must be fully conversant with the Health Board's and respective Directorate's approach to risk management and governance. They will support the application of this framework and its related processes and participate in the monitoring and auditing process.

All Staff

All staff will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety, and all others that may be affected by the Health Board's business;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work, and the notification to their line manager of any perceived risk that may not have been assessed; and
- be aware of the Health Board's Risk Management Framework and processes, and the local strategy and procedures, and comply with them.

Contractors employed by the Health Board e.g. capital and estates specialists

It is the responsibility of each contractor employed by the Health Board to ensure that any staff working on their behalf is fully conversant with both PTHB's and their own organisations risk management requirements for the activity for which they are engaged.

9.3 Internal Audit

The relationship between risk management and Internal Audit is critically important. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;
b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;
c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;
d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with matters arising from audit work.

9.4 Audit Wales

The Health Board's risk management arrangements are reviewed annually as part of the Audit Wales's Structured Assessment process.

9.5 Local Counter Fraud Services

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the Audit, Risk and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit, Risk and Assurance Committee as appropriate.
The LCFS works with the Chief Executive, Executive Directors and Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned and are then escalated through the Health Board's escalation process.

9.6 Committee Duties and Responsibilities

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. Specific duties and responsibilities are set out in the table below:

The Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee is responsible for overseeing risk management processes across the organisation, and will have a particular focus on seeking assurance that effective systems are in place to manage risk; that the organisation has an effective framework of internal controls to address strategic risks (those likely to directly impact on achieving strategic objectives); and, that the effectiveness of that framework is regularly reviewed.

The Committee is responsible for monitoring the assurance environment and challenging the levels of assurance in respect of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied upon, and reviewing the internal audit plan in-year as the risk profiles change.

The Executive Committee

The Executive Committee has responsibility for ensuring implementation of the risk management process and has responsibility for agreeing the risks on the ORR, and the SRR and BAF, prior to consideration and approval by the Board.

The Executive Committee has the responsibility to discuss the BAF and any amendments, to ensure there is appropriate scrutiny and challenge of strategic risks, the current controls and assurances in place and the actions to address any gaps in these, prior to the BAF being submitted to the Board for consideration and approval.

It is also the role of the Executive Committee to agree that strategic and organisational risks are being managed to an acceptable level, balancing

priorities, resources and the risk to the Health Board, and recommending the best course of action to manage the risks, to the Board. The Board must be provided with assurance that everything that can be done is being done to reduce the risk, and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the Health Board. Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures will be regularly reviewed to ensure that they remain effective.

Relevant Sub-group of Executive Committee

The Risk and Assurance Group is a sub-group of the Executive Committee. The Group reports to the Executive Committee and advises on any risk management issues, including all significant operational risks.

The Group is responsible for supporting the implementation of the risk, control and assurance processes established within the organisation. The Group will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (service level, directorate and organisational) and the Board's SRR and BAF.

Specifically, the Group is responsible for:

- Coordinating the achievement of the Risk Management Framework's objectives, through the organisation's directorates, by embedding risk management promoting the integration of risk and assurance management.
- Regularly reviewing Directorate Risk Registers, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate.
- Reviewing updates to the Organisational Risk Register (ORR), and maintaining clear links with the Assurance Framework;
- Discussing and recommending the escalation and de-escalation of risks from/to the ORR for Executive Committee consideration when appropriate by ensuring significant risks are appropriately prioritised. Reviewing and monitoring closely risks that are identified by members as of potential significance organisationally however are not deemed to meet the criteria for inclusion within the ORR.
- Providing a 'Risk Champions' forum for support in relation to all aspects of risk management including sharing best practice and providing appropriate peer review and challenge to enable cross organisation consistency in the application of the Risk Management Framework and its supporting documents.

Directorate Risk Management Arrangements

All directorates must have the necessary arrangements in place for good governance, quality, safety and risk management and should align with corporate guidance and systems where required e.g. the use of standardised templates, systems and processes.

Directorates, through management, have responsibility for risks to their services and for the management of those risks in accordance with this framework. Directorates are also responsible for developing local arrangements for the monitoring and reporting of risk information both internally within their respective directorate and in accordance with the requirements of the Risk and Assurance Group

10. Risk Management Toolkit

To support delivery of the Risk Management Framework, a toolkit is available for staff on the intranet. The toolkit is a means by which the Risk Management Framework is operationalised to put into effect the full range of activities outlined. The toolkit includes:

- Risk Management Process
- Risk Assessment Procedure
- Risk Scoring Matrix
- Risk Register Procedure
- Risk Register Template & Guidance

The Risk Management Toolkit will be reviewed in 2025-26 to align with the updated Risk Management Framework. For any queries in relation to the Risk Management Toolkit or its content please contact:

powysdirectorate.corporategovernance@wales.nhs.uk

11. Risk Management Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members	Review of Risk Appetite Risk Awareness Training	Annual Every 2 years
Risk and Assurance Group /Risk Register Coordinators	Risk Awareness Training, including Risk Assessment and Risk Register Training	Every 3 Years
Service Managers / Risk Owners	Bespoke training delivered on a needs-based approach	Ad hoc / as required
All Staff	Open invite Risk Awareness Training	Annual

12. Monitoring the Effectiveness of the Risk Management Framework

Compliance with this Framework is monitored by the Executive Committee and the Audit, Risk & Assurance Committee.

The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process.

13. References

ISO 31000:2018: ISO 31000:2018(en), Risk management — Guidelines

Academi Wales (2017) The Pocket Guide to Governance in NHS Wales. Available at: Pocket Guide for NHS Wales Boards English.pdf

UK Government (2023) The Orange Book – Management of Risk – Principles and Concepts

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.8

Audit Risk and Assurance Committee	**Date: 11 March 2025**
Subject:	Counter Fraud Annual Work Plan 2025/26
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:	Executive Committee - 19 February 2025 who supported the work plan.

PURPOSE:

The Counter Fraud Work Plan 2025/26 is presented to the Audit Risk & Assurance Committee to seek approval. Planned activity is set out around key areas of work intended to be undertaken by the Local Counter Fraud Specialists during 2025/26 and takes account of the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the Counter Fraud Work Plan 2025/26
- **APPROVE** the Counter Fraud Work Plan 2025/26.

Approve/Take Assurance	Discuss	Note
Y	N	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 Work Plan 2025/26 is devised to take account of organisational and national fraud risks as well as set out activity aimed at ensuring compliance with the NHS requirements of the Counter Fraud Government Functional Standards.
HEADING:
See attachment

NEXT STEPS:
The Committee is asked to Approve the Counter Fraud Work Plan 2025/26.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT
This section must be completed for all strategic organisational decisions including approval of health board policies.

Counter Fraud Work Plan 2025/26

Matthew Evans
Head of Counter Fraud Services

Introduction

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

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

INFORM AND INVOLVE			
The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
I&I.1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	GovS 013 component 11	Throughout the Year
I&I.2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	GovS 013 component 11	Throughout the Year
I&I.3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	GovS 013 component 11	Q2 and Q4
I&I.4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	GovS 013 component 11	Throughout the Year
I&I.5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	GovS 013 component 11	Throughout the Year

INFORM AND INVOLVE			
The Organisation is required to maintain an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
I&I.7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other "beware" notices and relevant messages.	GovS 013 component 11	Q2 and Q4
I&I.8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	GovS 013 component 11	Q2
I&I.9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	GovS 013 Components 4, 7 and 12	Throughout the Year
I&I.10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 Components 7 and 12	Throughout the Year
	TOTAL DAYS ALLOCATED	**60**	

PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.1	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 GovS 013 component 10	As Appropriate
P&D.2	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
P&D.3	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5	Throughout the Year

PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.4	Review existing fraud risk assessments with Risk Owners.	GovS 013 component 2 GovS 013 component 3 GovS 013 component 5 FR01, FR02, FR03, FR04, FR05, FR06, FR07, FR25, FR34, FR59	Q2
P&D.5	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010.	GovS 013 component 12	Q1
P&D.6	Utilise National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10	Q2
P&D.7	Finalise fraud risk assessment around identified issue of False International English Language Testing System Certificates (IELTS)	FPN H-005-23	Q1

PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.8	Finalise fraud risk assessment centred on falsifying timesheets and expense claims	FPN – L-001-25	Q1
P&D.9	Finalise fraud risk assessment in relation to Mental Health Act s.12 Assessments claims	FPN – M-002-25	Q2
P&D.10	Review both FR08 & FR09 around updated issue of Mandate Fraud. Seek to amalgamate both risks into one comprehensive risk assessment to streamline future review of this ever evolving fraud risk	FPN – L002-23	Q1
P&D.11	Review FR22 in response to the identified issue of CEO/Unsolicited Payment Requests	FPN-M001-24	Q1
P&D.12	Review and update information sharing protocols currently in place.	Service level	Q1
P&D.13	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Service level	Throughout the Year
P&D.14	Record and respond to ad-hoc requests for assistance received.	Service level	Throughout the Year

PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.15	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
P&D.16	Issue of fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
P&D.17	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level	Throughout the Year
P&D.18	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	GovS 013 component 10	Throughout the Year
P&D.19	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required

PREVENT AND DETER			
The organisation must carry out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. **The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.** **The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
P&D.20	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line.	GovS 013 component 10	Throughout the Year
P&D.21	Membership of Local Intelligence Network and attendance at meetings.	Service level	As Required
	TOTAL DAYS ALLOCATED	**103**	

HOLD TO ACCOUNT			
The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. **The organisation must have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption.** **The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA.**			
	TASK/OBJECTIVE	**RISK/FPN/STANDARD**	**PROPOSED DELIVERY**
HTA.1	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As Required
HTA.2	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 GovS 013 component 8	As Required
HTA.3	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	GovS 013 component 9	As Required
HTA.4	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	GovS 013 component 6 GovS 013 component 9	As Required
HTA.5	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	GovS 013 component 6 GovS 013 component 8	As Required

HTA.6	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1
	TOTAL DAYS ALLOCATED	**100**	

STRATEGIC GOVERNANCE			
A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. **The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.** **The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.**			
TASK/OBJECTIVE			**PROPOSED DELIVERY**
SG.1	Attendance at all Fraud Forum meetings held by CFS Wales.	Service Level	As Required
SG.2	Completion and agreement of the annual work plan with Director of Finance.	GovS 013 component 2	Q4
SG.3	Completion and agreement of the annual report with Director of Finance.	GovS 013 component 5	Q1
SG.4	Regular meetings/liaison with Director of Finance.	GovS 013 component 1	Throughout the Year
SG.5	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
SG.6	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service Level	Q4 and As Required
SG.7	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service Level	As Required

STRATEGIC GOVERNANCE			
A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. **The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.** **The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience.**			
	TASK/OBJECTIVE		**PROPOSED DELIVERY**
SG.8	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	GovS 013 component 8	Throughout the Year
SG.9	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	GovS 013 component 6	Throughout the Year
SG.10	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 GovS 013 component 7	Q2
SG.11	Attendance at Counter Fraud Joint Working Group monthly meetings.	Service Level	Throughout the Year
	TOTAL DAYS ALLOCATED	**45**	

SUMMARY TOTALS		
	STRATEGIC AREA OF ACTIVITY	**RESOURCE ALLOCATED (in days)**
A	**INFORM AND INVOLVE**	60
B	**PREVENT AND DETER**	103
C	**HOLD TO ACCOUNT**	100
D	**STRATEGIC GOVERNANCE**	45
	TOTAL	**308**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.1

Audit Risk and Assurance Committee	**Date: 11 March 2025**
Subject:	**ANNUAL ACCOUNTS 2024/25** Timetable and Principles for the Financial Methodology and Approach at Year End
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Capital Estates and Support Services
Prepared by:	Deputy Director of Finance Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is to provide the Audit, Risk & Assurance Committee with an outline of the approach and principles to be adopted for completion of the 2024/25 Annual Accounts together with the planned approach to key financial areas.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** the content of this report; specifically
  - the timetable, key dates and milestones for the submission of the Annual Accounts for 2024/25;
  - the arrangements in place for the review and adoption of the Annual Accounts;
  - the approach for accounting for capital issues;
  - the approach for accounting for primary care accruals;
  - the approach for accounting for retrospective continuing health care claims;
  - the anticipated movements in other key provisions;
- **NOTE** the planned approach to accounting areas including use of estimates where needed as outlined within the paper.
- Take **ASSURANCE** that appropriate arrangement are in place for the review and adoption of the Annual Accounts 2024/25.

Approve/Take Assurance	Discuss	Note
Y	N	Y

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

EXECUTIVE SUMMARY:

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

DETAILS AND BACKGROUND:

The purpose of this paper is to update the Committee on the plans in place to close the Annual Accounts for the year ending 31 March 2025.

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

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

NEXT STEPS:

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

IMPACT ASSESSMENT - NOT REQUIRED FOR THIS REPORT

1. INTRODUCTION

1.1. The purpose of this paper is to provide the Audit Committee with a briefing on the plans in place to close the Annual Accounts for the year ending 31st March 2025.

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

2. BACKGROUND

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

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

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

Annual Accounts Task	Deadline
Issue NHS Debtor Balance Statements to other NHS Wales bodies	2 April 2025
Sign off date for Agreement of NHS Wales Debtors & Creditors	7 April 2025
Issue Income transactions to NHS Wales bodies	9 April 2025
Sign off date for agreement of NHS Wales Income & Expenditure	16 April 2025
Finalise Health Board Outturn Position	8 April 2025
Close Health Board old year financial ledger	8 April 2025
Submit LMS to Welsh Government	17 April 2025
EASTER	18 – 21 April 2025
Preparation of draft Accounts Senior Finance Team review	25 April 2025
Submission of Draft Accounts to Welsh Government	2 May 2025 (noon)

Annual Accounts Task	Deadline
Submission of Draft Accountability Report and Performance Overview (including Remuneration Report) to Welsh Government	9 May 2025
Submission of Audited Accounts	30 June 2025 (noon)

2.4. To note these timescales are reduced in comparison to 2023/24 due to the Audit Wales planned move away from the extended 2022/23 audit timeline previously communicated to all NHS Wales bodies. Details of this is included within the committee papers under the Audit Wales Audit Plan/Update.

3. GOVERNANCE AND RISK ISSUES

3.1. The Audit Committee meeting scheduled for Tuesday 13th May 2025, will receive the draft Annual Accounts, Accountability and Performance Report and the Remuneration Report.

3.2. A provisional meeting of the Audit Committee has been arranged 17th June 2025. This meeting will be to review the full audited statements and reports, with a Board meeting to formally adopt them scheduled for 25th June 2025. The deadline for submission of the approved audited accounts and associated reports to Welsh Government is indicated to be 30th June 2025.

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

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

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

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

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

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

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

A. CAPITAL ISSUES

i. De-recognition

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

ii. IFRS 16

International Financial Reporting Standard (IFRS) 16 Leases came into effect on 1st April 2022. It provides a single lessee accounting model and requires a lessee to recognise right-of-use assets and liabilities for leases with a term more than 12 months unless the underlying value is of low value.

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

This note will continue to be updated to include new leases taken out and any change to existing leases since 1st April 2025.

B. PRIMARY CARE ACCRUALS

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

The Health Board has reviewed the accounting methodologies used across the primary care accrual areas last year. This review has taken into consideration actual outturn values against accrual values and whether there have been any amendments to primary

care contracts in year to determine whether any changes are required for 2024/25. The outcome of this work has concluded the following:

i. GMS Enhanced Services

Given the timescales allowed for practices to claim Enhanced Services, some of the claims may not be received until the following years, therefore, the HB is required to estimate the final out-turn. The HB would review the latest claims from each practice for each enhanced service and estimate the final out-turn, by taking account of current or prior year trends (where seasonality impacts) on the given service. The accrual will be based on best estimates and information available at M12 and clearly identified in a working paper.

ii. GMS QIF (Quality and Improvement Framework)

Under the QIF scheme, GP Practices achieve a certain level of points and these are multiplied by £x value per point (varies depending on practice weighted list size) to establish the payments due.

iii. Pharmacy Contract

No changes are proposed for the approach to calculating the accruals from 2023/24. Estimates will predominantly be an adjusted straight line, which includes any adjustments for additional identified costs as part of the year-end review.

iv. Primary Care Prescribing

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

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

The continued variable trend, month on month in 2024/25 has required the Health Board to add trend forecasting to the information identified above when calculating a position to forecast.

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

C. RETROSPECTIVE CONTINUING HEALTH CARE CLAIMS (OMBUDSMAN PROVISION)

i. Background

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

During 2014, the Welsh Government launched an advertising campaign to draw the public's attention to the cut-off date for retrospective continuing NHS health care claims relating to the period 1st April 2003 to 31st July 2013 (Phase 3). Claimants needed to register their intent to claim by 31st July 2014, and no later than 31st December 2014 (later extended by Welsh Government to 31st January 2015), to provide evidence of their right to make the claim and proof of fees paid to the care home or domiciliary agency. The intent to claim and the supporting documentation had to be submitted to the All Wales Retrospective Review Team within Powys HB.

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

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

Further annual publicity campaigns have resulted in the ability to claim for periods post July 2013. For phase 4 and subsequent phases, the average success rate will be continued to be used to make a reliable estimate for probable claims based on the average weekly rate. All phase 4,5 & 6 cases have now been settled. As at 31st March 2025 a provision will be provided for the phase 7 claims, currently recording 13 cases.

D. REPORTING ISSUES

i) Pension 6.3%

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

A transitional approach was agreed with the Business Services Authority, whereby an employer rate of 20.68% will apply from 1 April 2019. However, from 2019-20 the Business Services Authority has only collected 14.38% from NHS Wales bodies. Central payments have been made by Welsh Government for the outstanding 6.3% on behalf of NHS Wales bodies. This continues in 2024/25.

It is important that notional transactions are recorded in NHS Accounts to record the true costs of the pension contributions the bodies have incurred. Therefore, adjustments are made in the accounts for the 6.3% and a specific note is completed under Note 34 Other Information to explain the relevant accounting entries to the

reader of the accounts. The amount to be included will be provided to the Health Board by Welsh Government but will be compared to the 14.38% contribution payable by Powys THB for reasonableness.

ii) Scheme Pays

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

For the 2019/20 accounts no disclosure with regard to this policy was provided as the information to determine whether a provision or contingent liability was required was not available. For the 2020/21 accounts a narrative contingent liability note was disclosed detailing the scheme as insufficient information was available to support a provision. For the 2021/22 accounts a provision was required for the future costs of this commitment by NHS bodies. Welsh Government is working with the NHS Pensions Agency and Government Actuaries Department to identify the estimated costs for each health body and there will be a requirement for each health body to disclose a provision in the 2024/25 accounts. There will not be an impact to the financial performance of the Health Board as Welsh Government has advised that, as in 2023/24, the provision will be offset within the financial statement by a debtor to Welsh Government. This is similar to the process for the Welsh Risk Pool.

E. MOVEMENT IN OTHER KEY PROVISIONS

I. Early Retirement Pension Provision / Permanent Injury

There has been a further change in the Discount Factors to be applied in line with the draft Manual for Accounts issued by Welsh Government in December 2024. This directs health boards to use 2.40% this year (2.45% 2023/24). Together with a recent change in life expectancy will result in a financial cost increase of £0.078M this year.

PTHB also account for the permanent injury provision in respect of a former member of staff of Health Authorities which were reorganised into Health Boards in April 2003. This provision although not material within the THB accounts is funded by Welsh Government in the THB allocation letter and, therefore, any financial impact on movement of this provision year on year is covered by this funding. Together with a recent change in life expectancy will result in a financial cost increase of £0.039M this year which is slightly less than the funding provided.

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

As is the case for previous years, to comply with the requirements of IAS 37: Accounting for Provisions, Welsh Government has issued guidance regarding the

accounting treatment of defence fees for legal claims where the chance of success is deemed as possible (6-49% chance of success).

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

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

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

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

In 2023/24 the Health Board provided on the basis outlined in the table above with the percentages used to provide for probability 3 cases being 28% for Clinical Negligence cases and 56% for Personal Injury cases. This percentage has been revisited in 2024/25 and has been revised to 48% for Clinical Negligence cases and 59% for Personal Injury cases. Based on the 3rd quarter quantum reports from Welsh Health Legal Services this has resulted in a increase in the provision of £0.117M. This figure may be subject to change as more recent quantum is received.

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

III. Accounting for Redress Provisions

At the end of the 2018/19 financial year responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool. At the same time, Welsh Risk Pool changed the accounting requirement for redress cases from a cash basis to an accruals basis, therefore, requiring provisions to be included in the 2018/19 accounts for redress cases for the first time. This accounting treatment is again in place for 2024/25 with provisions for redress cases being included in the accounts based on estimated claim costs provided locally by the Concerns Team. Therefore, as at month 10 a provision of £0.097M is anticipated for this scheme in the 2024/25 year-end accounts. This amount may be subject to change based on the receipt of March 2025 quantum's but is not expected to be significant. As all payments made in respect of redress cases except for the claimant's legal costs (capped at £1,920) are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

IV. GP Indemnity Scheme

As of 1st April 2019, Welsh Government introduced a state backed future liabilities scheme for GPs and their staff to reimburse claims for clinical negligence against General Practice. The scheme covers claims relating to treatment post 1st April 2019 and is operated through Welsh Risk Pool. To date the health board has received eleven claims under this scheme with six remaining ongoing. Therefore, as at month 10 a provision of £2.381M is anticipated for this scheme in the 2024/25 year-end accounts. This amount may be subject to change based on the receipt of March 2025's quantum. As all payments made in respect of such cases are reimbursable from Welsh Risk Pool, the provision will be offset by a corresponding Welsh Risk Pool debtor.

F. Other Matters

i) Annual Leave

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

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

ii) Continuing Health Care

No changes are proposed for the approach to calculating the accruals from 2023/24. Accruals will be based on the NCCD maintained by the service.

iii) Commissioning Contracts (note NCA no change)

The LTA arrangements are as follows:

- English Contracts – through the year an agreed cash value is paid to each provider monthly. However, as the contract is in the main on a cost per case agreement using the English Tariffs rates, work is required to estimate the impact of actual performance in the Annual Accounts using the most up to date information available. Final settlement of this creditor / debtor will not be resolved until early summer once the full MDS data has been received and reviewed in detail by the Health Board.

- Welsh Contracts - paid in year at an agreed value based on historic activity and financial values uplifted by an All Wales %. At the end of the year contract performance is agreed using a marginal rate and finalised prior to the end of the financial year as part of the intra NHS Balance Agreement process.

iv) Pay matters

Currently, on an All Wales basis, consideration is being given to whether the banding of some Health Care Support Workers is appropriate and in line with Agenda for Change. NHS Employers is co-ordinating this work on behalf of Heatlh Boards and Trusts. This exercise could lead to some HCSW roles being moved from a Band 2 to a Band 3, which would translate to an increased cost. The situation is being monitored and the Health Board will seek to work on an All Wales basis to determine the correct accounting treatment.

4. REMOTE WORKING

It is anticipated that the Audit Team will be working remotely for the period of the audit although this has not been formally communicated. The THB finance department continue to work closely with the Audit Wales Team to make arrangements for information flow and communication methods to facilitate this and it is not anticipated that this approach will be detrimental to the delivery of the Audit. The THB and Audit Wales teams, as in previous years, will utilise the Inflo software for provision of working papers and responses to audit queries.

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

Agenda item: 7.2

Audit, Risk and Assurance Committee	**11 March 2025**
Subject:	**POWYS TEACHING HEALTH BOARD (PTHB) BOARD MEMBERS DECLARATION OF INTERESTS, GIFTS and HOSPITALITY 2024/2025**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Business Officer
Other Committees and meetings considered at:	Executive Committee - 19 February 2025

PURPOSE:

This paper presents the position on 12 February 2025 in respect of Register of Interest and Gifts and Hospitality for Independent Members and Executive Directors and updates on developments being made to the processes.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the contents of Register of Interests, Gifts and Hospitality for PTHB Board Members at 12 February 2025; and
- take **ASSURANCE** that the organisation has appropriate processes to support the collection, management and reporting of Declarations of interest, Gifts and Hospitality in line with the Standards of Behaviour Policy.

The report will be provided to the Board on the 26 March 2025.

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

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

EXECUTIVE SUMMARY:

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

BACKGROUND

In accordance with the requirements of PTHB's Standing Orders and Standards of Behaviour Policy, a report is required to be received by the Audit, Risk and Assurance Committee (ARAC) which details the Declarations of Interest, Gifts and Hospitality received by Board Members.

The Register of Interests is maintained by the Corporate Governance Department with each declaration reviewed and checked by the Director of Corporate Governance with any queries addressed prior to entry on the register. The Department is responsible for issuing periodic invitations to employees and Independent Members to declare their interests, gifts and hospitality. The register for Declaration of Interests 2024/25 at 12 February 2025 is attached at **Appendix A** and Register of Gifts and Hospitality received to date at **Appendix B.**

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

An escalation process has been implemented by the Corporate Governance Team to address instances in which declaration of interest forms have been requested from Executives and/or Independent Members but have not been submitted. Progress has been made in this area and the Corporate Governance Team is now pursuing best practice and encouraging all staff to declare interests where applicable.

To actively promote the Standards of Behaviour Policy and Declarations of Interests across the organisation, the Corporate Governance Team is reviewing current processes of how declarations are made and recorded. In addition, work

is underway to develop a communications plan, and to streamline the process of which declarations are made and recorded.
The Standards of Behaviour Framework summary is set out here: Standards-of-behaviour-framework and (available on request). The Director of Corporate Governance has reviewed the declarations made by Board Members and can confirm that no interest declared requires escalation to the Committee. The Register is available on PTHB's website and is also added to all Board and Committee agendas to ensure openness and transparency.

NEXT STEPS:

The Standards of Behaviour Policy is under review and is due to considered by the Board on 26 March 2025.

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

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25

Updated: February 2025

Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/02/2025	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	Feb-25	Current	Director of Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment		

		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	08/07/2024	
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owneer:Property in the County of Powys	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		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		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL		

and Support Services		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2024	
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance / Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic	**Lucie Cornish**								

Improvement and Transformation		Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Apr-24	Current	Independent Member – ateb - housing Association	£2,960 Per Annum	29/01/2025	
				Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary		
		Spouse/Partner or other Relative	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil		
				Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board	Nil		

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

Date of Gift	Donor/Contact Name	Item Donated	Organisation	Channel received	Notes	Value likely to exceed £25	Accepted/Declined
03.05.2024	Databricks	Mini Jenga Game Mug Scented Candle Hot Chocolate Powder	Databricks 22 Berners St London W1T 3LR	Post	Posted to Bronllys Hospital, PTHB	No	Accepted by Data Services
20.12.2024	Susan Read 3 Mineah Drive, Guilsfield,SY21 9LZ	One750-ml bottle of Yellow Tail Chardonnay wine	Public		N/A	No	Accpeted by Community Dental Service

Audit, Risk and Assurance Committees 2024-25

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board Glossary (January 2025)

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
AFC	Agenda for Change
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
ABUHB	Aneurin Bevan University Health Board
AR	Audit Recommendations
AGW	The Auditor General for Wales
BAF	Board Assurance Framework
BMA	British Medical Association
BCUHB	Betsi Cadwaladr University Health Board
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
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
CV	Curriculum Vitae
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CCN	Childrens Community Nursing
CTMUHB	Cwm Taff Morgannwg University Health Board
CVUHB	Cardiff and Vale University Health Board
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DATIX	Incident Management System
DPA	Data Protection Act
DGH	District General Hospital
DToC	Delayed Transfer of Care
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EMRTS	Emergency Medical Retrieval & Transfer Service?
ESR	Electronic Staff Record
EOY	End of Year
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
FBC	Full Business Case
GIRFT	Getting It Right First Time
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HPF	Healthcare Professionals Forum
HDUHB	Hywel Dda University Health Board
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
LMC	Local Medical Committee
LPF	Local Partnership Forum
LTA	Long Term Agreement
LHB	Learning Health Board
LA	Local Authority
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MD	Ministerial Direction
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
OCP	Organisational Change Process

OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
OBC	Outline Business Case
PA	
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
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RN	Registered Nurse
RPB	Regional Partnership Board
RIIC	Research, Innovation & Improvement Coordination
RISP	Radiology Information System Procurement
RPB	Regional Partnership Board
RTT	Referral to Treatment
RJAH	Rhobert Jones Agnus Hunt
RTS	Routemap To Sustainability
RIF	Regional Investment Fund
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SBUHB	Swansea Bay University Health Board
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
WPOCT	Welsh Point of Care Test System
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
WPAS	Welsh Patient Administration System
YTD	Year to Date