

Audit, Risk and Assurance Committee

Tue 14 January 2025, 10:00 - 12:00

Agenda

10:00 - 10:00 1. PRELIMINARY MATTERS

0 min

 ARAC_Agenda_14JAN2025 - Final.pdf (3 pages)

1.1. Welcome and Apologies

Information *Chair*

1.2. Declarations of Interest

10:00 - 10:00 2. CONSENT AGENDA BUSINESS

0 min

10:00 - 10:00 3. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

0 min

3.1. Minutes from the Previous Meeting held 08 October 2024

Attached *Chair*

 ARAC_3.1_Minutes 08 October 2024.pdf (11 pages)

3.2. Committee Action Log

Decision *Helen Bushell*

 ARAC_3.2_Action Log January 2025.pdf (1 pages)

10:00 - 10:00 4. ESCALATED ITEMS

0 min


10:00 - 10:00 5. ITEMS FOR ASSURANCE

0 min

5.1. Internal Audit Progress Report 2024-25


Assurance *Head of Internal Audit*

 ARAC_5.1_Powys ARAC Internal Audit Progress Report January 25 Cover.pdf (2 pages)


 ARAC_5.1a_Powys ARAC Internal Audit Progress Report January 25.pdf (22 pages)

5.2. Internal Audit Reports:


Assurance *Head of Internal Audit*

 ARAC_5.2_PTH-2425-15 Core Financial Systems - Treasury Management Final Internal Audit Report.pdf (19 pages)

 ARAC_5.2a_PTH-2425-02 Board Effectiveness Final Report.pdf (6 pages)

 ARAC_5.2b_PTHB-2425-18 Record Management Final Report.pdf (9 pages)

 ARAC_5.2c_PTH-2425-11 Staff Retention Final Internal Audit Report.pdf (14 pages)

 ARAC_5.2d_PTHB-SSU-2425-26 Capital Systems.pdf (12 pages)

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- 📄 ARAC_5.2e_PTHB-SSU-2425-25 Energy Management.pdf (10 pages)
- 📄 ARAC_5.2f_PTH-2425-15 Deprivation of Liberty Safeguards Final Internal Audit Report.pdf (17 pages)

5.3. External Audit Progress Report 2024-25

External Audit

- 📄 ARAC_5.3_Audit Wales Update January 2025.pdf (12 pages)

5.4. External Audit Reports

No reports for this meeting

5.5. Counter Fraud update

Head of Local Counter Fraud

- 📄 ARAC_5.5_Counter Fraud_Cover paper Report.pdf (2 pages)
- 📄 ARAC_5.5a_Counter Fraud Update Report.pdf (3 pages)

5.6. Post Payment Verification

Post Payment Verification Manager

- 📄 ARAC_5.6_PPV Mid-Year Report 2024-2025.pdf (4 pages)
- 📄 ARAC_5.6a_Powys Audit Report Mid-Year 2024-2025.pdf (1 pages)

5.7. Single Tender Waiver

Director of Finance, Capital and Support Services

- 📄 ARAC_5.7_Application for Single Tender Waiver Cover report.pdf (2 pages)

5.8. Records Management

Director of Corporate Governance

- 📄 ARAC_5.8_Committee Paper for RM Imp Plan - Jan 2025.pdf (8 pages)
- 📄 ARAC_5.8a_Appendix 1 - Records Management audit recommendations overview.pdf (1 pages)

10:00 - 10:00 6. ITEMS FOR DISCUSSION

0 min

10:00 - 10:00 7. CONSENT AGENDA

0 min

7.1. Work Programme

- 📄 ARAC_7.1_2024-25 Work Programme.pdf (1 pages)

10:00 - 10:00 8. OTHER MATTERS

0 min

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

8.2. Any Other Urgent Business

8.3. Date of next meeting:

11 March 2025

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**AUDIT, RISK & ASSURANCE
COMMITTEE
TUESDAY 14 JANUARY 2025**



**GIG
CYMRU
NHS
WALES**

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

**10:00 – 12:00
VIA MICROSOFT TEAMS
CHAIR: STEVE ELLIOT**

AGENDA

Time	Item	Title	Attached /Verbal	Presenter
	1	PRELIMINARY MATTERS		
10:00	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
	2	CONSENT AGENDA BUSINESS		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
	3.1	Minutes from the Previous Meeting held 08 October 2024	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	4	ESCALATED ITEMS		
There are no items for inclusion within this section				
	5	ITEMS FOR ASSURANCE		
10:10	5.1	Internal Audit Progress Report 2024-25	Attached	Head of Internal Audit
10:20	5.2	Internal Audit Reports <ul style="list-style-type: none"> • Core Financial Systems – Treasury Management (Substantial Assurance) • Board & Committee Structure / Effectiveness (Substantial Assurance) • Records Management (Substantial Assurance) • Staff Retention (Reasonable Assurance) • Capital Systems (Reasonable Assurance) • Energy Management (Reasonable Assurance) 	Attached	Head of Internal Audit

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		<ul style="list-style-type: none"> Deprivation of Liberties Safeguards (Limited Assurance) 		
10:50	5.3	External Audit Progress Report	Attached	External Audit
10:55	5.4	External Audit Reports - No reports for this meeting		External Audit
11:10	5.5	Counter Fraud Update	Attached	Head of Local Counter Fraud
11:20	5.6	Post payment Verification (mid year report)	Attached	Director of Finance, Capital and Support Services
11:30	5.7	Single Tender Waiver (including extensions to contracts)	Attached	Director of Finance, Capital and Support Services
11:35	5.8	Records Management	Attached	Director of Corporate Governance
	6	ITEMS FOR DISCUSSION		
		There are no items for inclusion within this section		
	7	CONSENT AGENDA		
11:50	7.1	Work Programme	Attached	Director of Corporate Governance
	8	OTHER MATTERS		
11:50	8.1	Items to be Brought to the Attention of the Board and Other Committees	Verbal	Chair
11:55	8.2	Any Other Urgent Business	Verbal	Chair
	8.3	Committee Meeting Feedback	Verbal	Chair
12:00	8.4	Date of the Next Meeting: 11 March 2025		

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

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

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 – please 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.

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AUDIT, RISK AND ASSURANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON TUESDAY 08 OCTOBER 2024 AT 10:00AM VIA MICROSOFT TEAMS

MEMBERS		
Rhobert Lewis	RL	Independent Member (Chair)
Ronnie Alexander	RA	Independent Member (General)
Steve Elliot	SE	Independent Member (Finance)
IN ATTENDANCE		
Anne Beegan	AB	Audit Wales (for Item 3.3)
Carl Cooper	CC	PTHB Chair (observer)
Fran Carapinha	FC	Corporate Governance Assurance and Risk Officer (Committee support)
Helen Bushell	HB	Director of Corporate Governance/Board Secretary (for Items 3.4 – 3.6, 3.11-3.12 and 5.1)
Ian Virgil	IV	Internal Audit (for Items 3.1 and 3.2)
Mathew Evans	ME	Counter Fraud (for Item 3.9)
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services and Deputy Chief Executive (for Item 3.8)
Sarah Pritchard	SP	Head of Financial Services (for Item 3.7)
Stewart Bodman	SB	Internal Audit (observer)
APOLOGIES FOR ABSENCE:		
Bethan Hopkins	BH	Audit Wales
Chris Walsh	CW	Independent Member (Local Authority)
Hayley Thomas	HT	Chief Executive Officer
Hywel Pullen	HP	Deputy Director of Finance
Laura Tovey	LT	Audit Wales
Mick Giannasi	MG	Independent Member (General)

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (ARA/24/042)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (ARA/24/043)
No declarations of interests were received in addition to those already on the register.

1.3 MINUTES OF PREVIOUS MEETING (ARA/24/044)

The minutes of the meeting(s) held on 9 July 2024 were **CONFIRMED** as an accurate record subject to the following amendments:

- Inclusion of apologies received

1.4 ACTION LOG (REF)

Three actions **NOTED** as closed and one action to be kept open for review:

- ARA/24/16–It was agreed the action to remain open until the Procedure including the Committee responsible for tracking high priority audit recommendations is included in the PTHB Handbook and presented at the January 2025 Committee.

The Committee **RECEIVED** and **NOTED** the Action Log.

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

3. ITEMS FOR ASSURANCE

3.1 INTERNAL AUDIT PROGRESS REPORT 24/25 (ARA/24/045)

IV introduced the progress report highlighting that the Executive Summaries of the Final reports are included in section 6 of the Progress report as those have been finalised since the last Audit Risk and Assurance Committee in July 2024. The full copy of the final reports are included as separate items in the agenda for information.

Current position with progress of the 2024/25 plan:

- Two audits have been finalised
- Seven audits are currently work in progress with planned delivery through the remainder of the year.
- IV outlined that management had requested that the audit of Mental Health Care and Treatment Planning move from Q2/3 to Q4 as the NHS Executive are currently undertaking a separate audit of Care and Treatment Planning.

A summary of the current performance against Key Performance Indicators was given as per the report, which was largely as expected, and the near completed reports were scheduled for the January Committee.

IV confirmed the new Global Internal Audit Standards (GIAS) which will become effective from January 2025 and will Apply to Public Sector Audits from 1 April 2025 to align with the New Financial Year. It is anticipated that no major changes will be required to the internal audit approach with the exception of one potential change around how we monitor and evidence the implementation of the agreed management actions.

Full details of the New Standards and the Impact on the delivery of the Internal Audit results, will be reflected in the Annual Plan presented to the Committee in March 2025.

The Committee raised the following question/observations:

is there confidence that any audits behind schedule will be delivered effectively on time during this reporting year?

Resources have been made available to support the delivery of the two audits that were not finalised in time to come to the Committee. We are

confident that we will be able to deliver the full plan in time to feed into the Opinion for this year.

Have Internal Audit considered the potential extra costs attached to the New Global Standards?

Our daily rates include a charge for additional work above the base rate and we don't anticipate that the New Global Standards are going to cause any change to our processes or that would lead to a change to the charge for our services.

As there are a high level of reports to be presented at the next meeting, can the reports be made available as they become available to make read easy?

A change of approach to how we circulate the reports can be discussed to issue reports before the Committee deadline.

The Committee **RECEIVED** the Internal Progress report and **NOTED** the adjustment to the 2024/25 plan.

3.2 INTERNAL AUDIT REPORTS (ARA/24/046)

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

- a) End of Life Care Services (Reasonable Assurance)
- b) Integrated Performance Framework (Substantial Assurance)
- c) Integrated Plan Development Process (Reasonable Assurance)
- d) Cleaning Standards (Reasonable Assurance)

a) End of Life Care Services (Reasonable Assurance)

IV Presented the report which reviewed the structures and processes in place for the provision of end-of-life care services for the residents of Powys.

The committee made the following observations:

- *The identified staffing issues and lack of medical provision is concerning, and we should seek clarification of the situation from the Medical Director.*
- *It is appreciated that EOL Care can be very short term but does the Audit process collect information on patient/family opinion on the delivery of EOL?*

IV confirmed that the audit process does not have the required clinical expertise, and it would be very challenging to manage the necessary interaction with the patient to collect data on patient opinion.

- *More work is required to make sure Directorate and Service context is linked to the Integrated quality and Performance framework to facilitate communication of concerns/issues to the Board Committee.*

b) Integrated Performance Framework (Substantial Assurance)

IV Presented the report which reviewed how the Integrated Performance Framework has been introduced and establish it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.

c) Integrated Plan Development Process (Reasonable Assurance)

IV Presented the report which reviewed the processes and assumptions used for developing the 2024/2027 Integrated Plan and Annual Delivery Plan with a focus on the assessment of financial plans.

The Committee made the following observations:

- Limited assurance was given to the statutory duty to break even when there was no assurance that we would break even in the short term. It is not clear the reasoning of Limited Assurance versus No Assurance.

IV confirmed that the term NO Assurance is no longer used and instead use Unsatisfactory Assurance to reflect the acknowledgement that the Health Board is making efforts to improve and meet the level of assurance required.

- The organisations current situation of enhanced monitoring for planning and finance, however not a contradiction does not correlate with the level of assurance reported in this interim report, but it does

a) Cleaning Standards (Reasonable Assurance)

IV presented the report which reviewed the processes and controls in place to ensure compliance with cleaning standards in place within the Health Board.

The committee made the following observations:

- *More clarity is required regarding the lines of reporting to Delivery & Performance Committee and Planning, Partnerships and Population Health Committee is required.*

HB suggested a further discussion regarding lines of reporting from the service to the relevant Committees is required.

ACTION: Director of Corporate Governance

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

3.3 EXTERNAL AUDIT PROGRESS REPORT 2024/25 (ARA/24/047)

AB presented the Audit Progress Report which provides an update on the current and planned accounts and performance audit work presented to the Committee in May 2024.

AB confirmed that an error in the report have now been corrected as follows:
- P7 Performance Audit update – says Financial Efficiency Status issued in draft. This is now complete and submitted.

The Committee asked if the planned review of arrangements for managing agency staff include Mental Health wards?

AB stated that when the exact scope of the work is developed, if Mental Health wards identified as valuable to the audit work, those will be included.

It was also agreed that, going forward, consideration will be given to introducing a staggered approach to presenting reports to the committee.

AB presented the Cost Savings Report which examines whether the Health Board has an effective approach to identifying, delivering and monitoring sustainable cost savings opportunities.

The report gives a summary of the audit findings supporting the audit overall conclusions and recommendations to accelerate the 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.

PH presented the Management Response to the recommendations which confirms that the Health Board accepts and welcome all the recommendations from the Audit Wales team.

In summary, the status of the audit recommendations is mostly complete and or complete and ongoing.

The committee made the following observations:

- *The number of recommendations addressed to the new Director of Improvement and Transformation will require some support by the wider Executive Team to make sure that the team can deliver change and the ongoing work around sustainability of the Health Board.*
- *Because a number of those recommendations are complete and ongoing, the process of tracking the dual status will require some further thought.*
- *The fact that the audit report identified the need to quantify both financial gain and the benefits to the patients as a result of the Accelerated Sustainable Model (ASM) is a positive.*

The Committee **RECEIVED** the report and **NOTED** the time scales for the presentation of the financial statements.

3.4 AUDIT REPORT – ROLES AND RESPONSIBILITIES (ARA/24/048)

HB presented an overview of the suggested roles and responsibilities relating to Internal and External Audit reports, as basis for discussion and to inform future work.

The presentation introduced the plan for development of an audit handbook in partnership with Internal and External Audit colleagues.

The objective of the audit handbook is to provide guidance, information, training and support to staff on how to respond to audit.

Special mention was given to the audit interviewees and the need to consider the environment and the culture to provide people with the confidence to speak freely and openly and willingly contribute to the audit.

The committee made the following observations:

- *We should make sure that the handbook and changes to the audit process are adopted gradually*
It is important to reflect on the reflections made and make sure that the changes proposed will materialise.

- *It is important that we tackle and manage issues triggered by the audit that are not particularly related to the audit process.*
- *Where recommendations are not accepted, a satisfactory/robust process to manage and potentially close those recommendations is required.*

The committee acknowledge and commended the effort involved in the new approach to make the Audit process clearer and more user friendly.

It was requested that a copy of the slide's presentation is made available to the Committee.

ACTION: Director of Corporate Governance

The Committee **CONSIDERED** the presentation outlining the suggested roles and responsibilities relating to the Internal and External Audit reports and demonstrated support towards the development of the Audit process Handbook.

3.5 AUDIT RECOMMENDATION TRACKER (ARA/24/049)

HB presented the Audit Recommendation Tracker (External and Internal Audit), which provides an overview of the position relating to the Implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 31 August 2024.

The following update on the Internal and External recommendation status was given:

Internal Recommendations

- 11 actions completed
- 35 not yet due
- 19 Outstanding or overdue

External Recommendations

- 0 actions completed
- 14 not yet due
- 1 outstanding or overdue

The report confirms there are no outstanding recommendations from Local Counter Fraud Services

The overall number of outstanding recommendations have increased from 13% to 21% since the last report. The increase relates to a small number of recommendations where response have not been received. This could be due to the recent gaps in the Executive Committee and Senior Structure.

The Committee asked the following question:

Is the audit team comfortable and satisfied with the speed and overall response rate of the Health Board?

IV confirmed as per the last audit review of actions at year end, there was an overall comfort with the response rate received from the Health Board.

The committee made the following observations:

- *It is necessary to recognise and investigate long overdue recommendations to identify the cause for those delays and or if those recommendations have been superseded or no longer appropriate.*
- *The status classification needs to be reflective and inclusive of recommendations that are no longer appropriate.*
- *The tracking process needs to be able to track how often deadlines are extended and record context that explains the current position.*

The Committee **CONSIDERED** the current position of outstanding recommendations and **TOOK ASSURANCE** that the organisation has an appropriate system for tracking and responding to Audit Recommendations.

3.6 BOARD ASSURANCE FRAMEWORK (ARA/24/050)

HB presented an update to the last approved Board Assurance Framework approved in May 2024.

The presentation focused particularly on the three main perspectives of the Board Assurance Framework (BAF), Strategic Risks, Board Assurance and Thematic reviews, and give the following updates:

- Strategic level risks – The process to manage strategic risks was reviewed in July 2024 and developed to incorporate corporate risks into the remit of committees. The corporate risk register has been improved and the process now enables review and discussion of those risks from top down into the Organisation at directorate level via the re-instated Risk and Assurance Group that meets bi monthly. This work is ongoing and will continue.
- Board governance – a system is being developed to undertake an assessment of assurance against regulatory documents and performance.
- The process to conduct thematic reviews – this area is not yet developed and still in the planning phase. The objective is to create an internal approach to carry out examination of specific areas with the aim to continually identify best practice and where improvements could be made. Expected to be commenced in 2025/26.

HB stated that there are plans to also develop a process to monitor the effectiveness of the Board Assurance Framework (BAF).

The Committee raised the following questions:

If I was asked today if we have a BAF, when would I be able to say that we have a fully working BAF?

A fully working BAF is expected in the next financial year. The Risk and the Board Governance elements of the BAF, are expected to be in place by the end of this financial year 2024/25.

The Committee **RECEIVED** and **NOTED** the Board Assurance Framework update.

3.7 LOSSES AND SPECIAL PAYMENTS (ARA/24/051)

SP presented the Interim report on Losses and Special Payments for the period 1 April 2024 to 31 August 2024 relating to payments made on behalf of cases for which PTHB have responsibility.

A full Annual report will be presented at the May 2025 Committee.

The committee raised the following questions:

This report excludes larger cases that tend to refer to large sums of money, such as cases involving general district hospitals?

Yes. The cases reported only include claims directly under the care of Powys Health Board within its provider or and with the GP services.

Is it possible to include some trend analysis from previous years on the Annual report?

Yes, feedback on trend analysis will be provided. We will also provide a snapshot of the Welsh risk pool report that shows the Health Board position in comparison to all Wales.

The Committee **RECEIVED** and **NOTED** the Interim Report for 2024/25 for Losses and Special Payments.

3.8 SINGLE TENDER WAIVERS (INCLUDING EXTENSIONS TO CONTRACTS) (ARA/24/052)

The Committee **NOTED** that no Single Tender Waiver requests were made between 1 July and 30 September 2024.

3.9 COUNTER FRAUD UPDATE (ARA/24/053)

ME presented the Counter Fraud Report update which gives an update on key areas of work undertaken by the Local Counter Fraud Specialists during 2024/25

ME explained the proposals to change the approach to counter fraud and made special reference to the following matters:

- Renewed emphasis on prevention
- Strengthening arrangements for staff to make referrals to Counter Fraud Services

The committee made the following observation:

As we move progressively towards employment of international doctors and nurses to support our staffing position, we must be scrupulous in the emigration status of the staff we employ.

Assurance has been given that the process to check emigration status have been strengthened within the Health Board locally, shared services and the recruitment team.

The Committee **RECEIVED** the update report for discussion and **TOOK ASSURANCE** that appropriate counter fraud systems are in place.

3.10 INFORMATION GOVERNANCE PERFORMANCE REPORT (ARA/24/054)

HB presented the report which provides 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.

The report relates to Q1 of 2024/25 (1 April 2024 to 30 June 2024) and highlights the following updates:

- 24 out of the 128 Freedom of Information (FOI) requests received, did not comply with the statutory target to reply. A rate of 90%.
- 4 out of the 199 Personal Information requests received did not comply with statutory target to reply. Showing improvement since last report.
- Information Governance (IG) Training shows 90% compliance.
- 31 Information Governance Incidents related reported.

Special attention was called to the current Executives's Mandatory training compliance of 84% (16 out of 19) which represents a non compliance with the National list.

The committee made the following observation:

It is necessary to seek clarity from ESR about Chief Executive office staff including IMs because the information given is sometimes contradictory.

The committee raised the following questions:

In terms of the Freedom of Information's breaches, is there a process to monitor and manage response times to minimise breaches?

Yes, there is a process in place that alerts staff for the timescales and how close a FOI request is getting to the deadline for response. Where delays are identified, we inform the requester and give an indication of the time scale.

Do some of the FOI requests involve our Commissioner Service Partners. This would impact on how we perform comparing to other Health Boards?

Yes. Arrangements will be made to include that information on the Annual report.

ACTION: Director of Corporate Governance

The Committee **RECEIVED** the contents of the report for assurance and **NOTED** any actions required to improve compliance.

3.11 STANDARDS OF BEHAVIOUR (ARA/24/055)

HB presented the report which presents the position on the 5 September 2024 in respect of declaration/register of Interest and Gifts and Hospitality for Independent Members and Executive Directors and updates on developments being made to processes.

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

3.12 WELSH HEALTH CIRCULAR (WHC) TRACKER (ARA/24/056)

HB presented the report which provides an overview of the current position relating to the Implementation of Welsh Health Circulars (WHCs) and Ministerial Directions (MD).

The following overview of the position as of the 12 September 2024 was given:

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

HB stated that the number of WHCs is increasing, and it is necessary to make sure that the systems are able to monitor and track those effectively.

The committee raised the following questions:

How often do we report on WHCs and Ministerial Directions? Is it necessary to look into making the process more systematic?

We report on WHCs and Ministerial Directions bi-annually and also into the annual accountability report and governance statements. The current mechanism in place to track and collect updates is relatively systematic and consideration will be given to automating the reporting to reduce the margin for error.

The Committee **RECEIVED** the report and **TOOK ASSURANCE** that the organisation has a system in place to receive, monitor and implement Welsh Health Circulars (WHCs) and Ministerial Directions (MDs)

4. ITEMS FOR DISCUSSION

There are no items for inclusion in this section

5. OTHER MATTERS

5.1 COMMITTEE ANNUAL WORK PROGRAM (ARA/24/057)

The committee **TOOK ASSURANCE** and **NOTED** the Annual work programme. There were no amendments or questions.

5.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES (ARA/24/058)

The following items were agreed to be brought to the Board and other Committees:

The committee suggested that the Internal audit recommendation to accelerate the route map for sustainability is brought to the attention of the Board

- HB suggested a further discussion regarding lines of reporting from service to Delivery & Performance Committee (D&P) and Planning, Partnerships and Population Health Committee (PPPH) is required

5.3 ANY OTHER URGENT BUSINESS (ARA/24/059)

The Committee noted this was Rhobert Lewis's (RL) last meeting as Chair of the committee. Committee members acknowledge his contribution to the Health Board and passed on their thanks. RL responded to extend his thanks to the Health Board and to all External and Internal Auditors and anyone else from outside the NHS who contribute to the Group.

5.4 COMMITTEE FEEDBACK (ARA/24/060)


Feedback provided in 5.3. No other feedback was received.

5.5 DATE OF NEXT MEETING

The date of the next meeting is scheduled on 14 January 2025 at 10:00 via Microsoft Teams.

Meeting closed at 12:58

Patterson, Liz
09/01/2025 16:35:11

Audit and Risk Assurance Committee								
 Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board								
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								
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	Oct-24	Mar-25	At risk
OPEN ACTIONS - none								
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 14 January 2025)								
08-Oct-24	ARA/24/048	Director of Corporate Governance	Audit Report - Roles and Responsibilities	It was requested that a copy of the slide's presentation is made available to the Committee.	14.01.25 update - slides were shared with committee members	Jan-25		Completed
08-Oct-24	ARA/24/054	Director of Corporate Governance	Information Governance Performance Report	To include information regarding involvement of commissioned services partners on the Annual Information Governance Report	14.01.25 update: Information will be included in the annual (year end report)	Jan-25		Completed
08-Oct-24	ARA/24/046	Director of Corporate Governance/ Ian Virgil (Internal Audit)	Internal Audit Reports	In respect of cleaning standards it was agreed a further discussion regarding lines of reporting from service to Delivery & Performance Committee (D&P) and Planning, Partnerships and Population Health Committee (PPPH) is required	14.01.25 update - discussion held and clarity of Committee roles considered - will form part of developing audit handbook.	Jan-25		Completed

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Powys Teaching
Health Board

Agenda Item: 5.1

Audit, Risk and Assurance Committee	14 January 2025
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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:

Objective	Y/N	
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	N	
7. Put Digital First	Y	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

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

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

- Core Financial Systems – Treasury Management (Substantial Assurance)
- Board & Committee Structure / Effectiveness (Substantial Assurance)
- Records Management (Substantial Assurance)
- Staff Retention (Reasonable Assurance)
- Capital Systems (Reasonable Assurance)
- Energy Management (Reasonable Assurance)
- Deprivation of Liberties Safeguards (DoLS) (Limited Assurance)

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

The progress report also includes details of a proposed adjustment to the 2024/25 plan, relating to the removal of the planned audit of Mental Health Care and Treatment Planning.

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
January 2025

NWSSP Audit and Assurance Services



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



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Appendix A	Assignment Status Schedule
Appendix B	Report Response Times
Appendix C	Key Performance Indicators
Appendix D	Assurance Ratings

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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

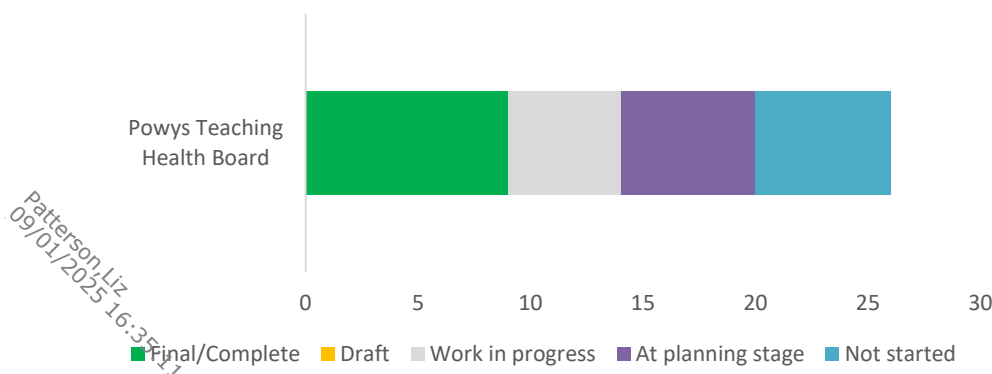
Seven assignments from the 2024/25 plan have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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	
Core Financial Systems – Treasury Management	Substantial	
Board & Committee Structure / Effectiveness		
Records Management		
Staff Retention	Reasonable	
Capital Systems		
Energy Management		
Deprivation of Liberties Safeguards (DoLS)	Limited	

3. Delivery of the 2024/25 Internal Audit Plan

There are a total of 26 reviews included within the 2024/25 Internal Audit Plan (Including the change highlighted in section 4), and overall progress to date is summarised below.



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

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

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

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

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

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

4. Changes to the 2024/25 Plan

The audit of Local Primary Mental Health Support Services has been proposed for removal from the 2024/25 plan. There has been an on-going significant delay in agreeing the scope of the audit which means that resource is no longer available for delivery.

As part of the planning discussions with the Executive Director of Primary, Community Care and Mental Health it will be determined if the audit should be included within the 2025/26 plan.

5. Development of the 2025/26 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors and Chief Executive during January 2025 to discuss potential areas for inclusion within the 2025/26 Internal Audit Plan. We are also attending a meeting of the Independent Members in January to obtain their thoughts on areas for the plan.

An initial draft plan will be submitted to a meeting of the Executive Committee during February for review. An updated draft will then be presented to the March Audit, Risk & Assurance Committee for formal approval.

6. Updated Report Template

As part of the Audit & Assurance Services' IMTP objectives for 2024/25, one objective focused on our reporting process/template as we recognised changes in reporting formats across the public sector, which included reviewing Welsh Government Internal Audit's new template. Following a period of review and consideration in the Service, a new template has been agreed, which ensures compliance with both the current Public Sector Internal Audit Standards (PSIAS)

and Global Internal Audit Standards being implemented from January 2025 (replacing the PSIAS from 1 April 2025).

This template will be operational across all NHS Wales organisations from 1st October 2024. However, reports that were in the process of being developed for on-going reviews will be in the old format. There may also be instances where this template may not be appropriate e.g. advisory / follow-up reviews, and we will adapt our report accordingly.

The key changes in the new template are summarised below:

- Report layout is now landscape;
- Reasonable assurance is now a lighter green assurance rating instead of yellow;
- Low risk recommendation has been removed and any opportunities for enhancement, that do not impact internal control, will now be noted to management as part of debrief meetings/correspondence;
- Executive Summary has expanded to capture key narrative for first glance of the key matters from the review;
- New Findings and Agreed Action Plan section – Includes an overview of the findings by each agreed objective with a key finding but no recommendation section; our approach to agreeing management action has changed where we will meet and agree the management response with the auditee. There is a new section to record what evidence we expect to see to support implementation. We have also added a Theme section which will classify what the key finding relates to and correlates to the Executive Summary page – Summary of Management Actions section.

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7. Final Report Summaries

7.1 Core Financial Systems – Treasury Management

Purpose

The overall objective of the audit is to evaluate and determine the adequacy of the systems and controls in place within the Health Board for Treasury Management.

Overview


We have issued substantial assurance on this area.

The matters requiring management attention include:

- The need to ensure that Financial Control Procedures are subject to regular review and updating.
- Bank mandates need to be reviewed to ensure that signatories are up to date and appropriate financial limits are stipulated.

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

Report Opinion

		Trend
	Few matters require attention and are compliance or advisory in nature.	N/A
Low impact on residual risk exposure.		

Assurance summary¹

Objectives	Assurance
1 Financial Control Procedure	Reasonable
2 Cash Forecast Production	Substantial
3 Cash Forecast Updates	Substantial
4 Receipts and Payments	Substantial
5 Transfers	Reasonable
6 Bank Account Reconciliations	Substantial

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority	
1	Financial Control Procedure Reviews	1	Operation	Medium
2	Bank Mandates / Account Access	5	Operation	Medium

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7.2 Board & Committee Structure/Effectiveness

Purpose

To evaluate Powys Teaching Health Board's (the 'Health Board') 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.

Overview

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

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

This review follows on from the previous audit of Board & Committee Structure/ Effectiveness which we completed in 2023/24, and covers the workings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee.



We have concluded **Substantial** assurance on this area. We have identified no key matters for reporting in our review.

Opportunities for Enhancement

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

- Consideration should be given to discussing with Welsh Government the potential of ongoing training and awareness exercises for Independent Members post-appointment, outside that already provided by the Health Board.

Scope & Assurance Summary

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

4
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7.3 Records Management

Purpose

Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.

Overview

The Information Commissioners Office (ICO) Records Management Code of Practice 2021 (Section 46) provides guidance to public authorities (and any other organisations whose administrative and departmental records are subject to the Public Records Act) on their obligations in relation to good records management, including keeping, managing and destroying records. Following the code of practice will help the Health Board to comply with the legislation.



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

- There is no fire suppression in the record storage areas.

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

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Appropriate policies, procedures and guidelines are in place for records management, that cover the full lifecycle and ensure standardisation of processes and content.		Substantial
2 Storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.	1	Substantial
3 Physical records are transported and tracked appropriately and are readily available for staff to access		Substantial
4 An appropriate process is in place to archive and dispose of records appropriately, both physical and digital		Substantial
5 The capacity, resilience and succession planning for the records function is appropriate to ensure compliance, recognising the continuing trend of increasing requests for support.		Substantial

Management Actions

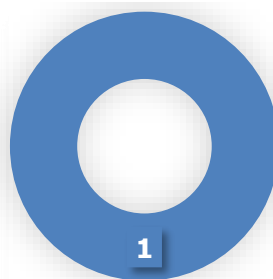


High Priority



Medium Priority

Themes



■ Physical Security



Risk Types

Public Perception & Reputational Risk

7.4 Staff Retention

Purpose

The overall objective of the audit was to review and assess 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.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Actions within the National Nurse Retention Plan overseen by the task and finish groups do not have revised target dates.
- The Health Board’s local Workforce Retention plan requires completion for use.
- Further work is required to promote the completion of exit questionnaires.

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

Report Opinion



Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 There are relevant plans in place that outline the approach to staff retention	Reasonable
2 Effective initiatives are in place to retain staff and outcomes are reviewed where applicable	Reasonable
3 There is a mechanism in place to collate and learn from information provided at the leavers exit questionnaire	Reasonable
4 There are appropriate governance arrangements in place, which provide an oversight for the regular review and delivery of retention plans.	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Setting Milestones for National Nurse Retention Plan actions	1	Operation	Medium
2	Development of Health Board’s Local Workforce Retention Plan	1 & 2	Operation	Medium
3	Exit Questionnaire Completion	3	Operation	Medium

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7.5 Capital Systems

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Audit Plan. Capital systems coverage during 2024/25 focussed on the selection, appointment and contractual arrangements applied at Capital and Estates projects (covering both advisers and contracts).

Background

Over the past few years, Capital and Estates have dedicated substantial time and effort to developing a structured control environment for their projects. This commitment has involved implementing a capital toolkit designed to enhance project management and oversight. By establishing clear processes and standards, the department has aimed to ensure consistency and quality across all projects.



We have concluded **reasonable assurance** in this area.

Whilst good compliance was noted in most areas, there were some matters that required further management attention e.g.:

- Developing appropriate contract strategies to ensure consistency in the contracts utilised and executed.
- Reviewing the capital procedures to ensure document retention criteria associated with construction contracts is appropriately defined.
- Standardising the level of detail in the procurement strategy for individual projects.
- Establishing mechanisms to track and monitor areas for improvement identified within the annual procurement reports.

Full detail of these matters is provided within the Findings & Agreed Action Plan. Additionally, the following opportunities for enhancement have been identified, which do not impact the overall opinion but are highlighted for management information:

- Horizon scanning for changes to procurement rules due to take effect from February 2025 and assessing how these may affect current operational processes.
- Exploring opportunities for training related to the upcoming changes to procurement rules.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Governance	-	Substantial
2 Contract Completion	1	Limited
3 Selection and Appointment	2,3	Reasonable
4 Value for Money and Award	1,2	Reasonable
5 Retention of contract and project documentation	4	Reasonable

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7.6 Energy Management

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

Overview

The Teaching Health Board's (THB's) energy consumption represents 2.3% of the NHS Wales total, with costs of circa £1.0m for gas and circa £1.0m for electricity reported for 2023/24.

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023.

Appropriate governance arrangements were in place, including an experienced Environment & Sustainability Team, reporting into the Environment and Sustainability governance structure.

We evidenced that the Environment & Sustainability Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review.

The THB is in the process of utilising re-fit monies of circa £4m to introduce or upgrade Building Management Systems (BMS) e.g. introduction of BMS at Welshpool Hospital and upgrade at Newtown Hospital.

The move to the new NHS Wales energy contract in 2023 had encountered some issues, including difficulties in providing accurate energy forecasts to participating organisations, and additional resource has been required from within the Energy Team to resolve account queries. Recognising the robust data processes operated at the THB, the impact of the national issues had not been as significant as seen elsewhere.



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

- Enhancing energy issue reporting through the inclusion of pertinent WEOG/WEG updates.
- Maintaining appropriate THB attendance at the all-Wales Energy group meetings (WEOG/WEG).
- The conducting of site walk-arounds as recommended by HTM07-02 Encode (Part A section 3.5)
- Consideration of additional energy risks for inclusion on the Estate's Risk Register.

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

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Governance	1	Reasonable
2 Contract	2	Reasonable
3 Data Capture		Substantial
4 Data Validation		Substantial
5 Monitoring and Reporting	3	Reasonable
6 Energy Awareness		Substantial
7 Payments		Substantial
8 Risk Management	4	Reasonable

Management Actions

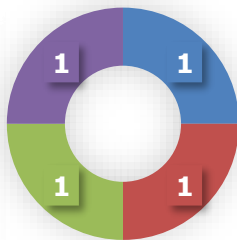


High Priority



Medium Priority

Themes



- Communication & Engagement
- Finance Management & Control
- Governance
- Risk Management

Risk Types

- Financial Loss
- Quality or Safety Issues

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7.7 Deprivation of Liberties Safeguards

Purpose

The overall objective of the audit was to review 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.

Overview:

We have issued Limited assurance on this area.

We note that following a period of difficulty for the DoLS process due to staff shortages within PTHB and PCC the situation is now improved but is not sustainable going forward. Clarity is required over the future provision of the DoLS Supervisory Body role and there are issues around capacity and delays in key stages of the DoLS application process.

The matters requiring management attention include:

- Review of the DoLS Policy;
- Ensuring appropriate on-going provision of training around the Managing Authority responsibilities;
- Contractor supplied Best Interest Assessors should have their qualifications confirmed periodically;
- Establishing a sustainable approach for the future delivery of the DoLS Supervisory Body role;
- Improvement to the process and timeliness for authorisation of DoLS applications; and
- Case tracking and Management Information could be improved with qualitative data as well as quantitative.

Report Opinion



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives	Assurance
1 Policy and procedure documentation	Reasonable
2 Training and Accreditation	Reasonable
3 Process Operation	Limited
4 Reporting	Limited

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Policy and process document	1 Design	Medium
2	Provision of Training on Managing Authority Responsibilities	2 Design	Medium
3	BIA contractor qualification	2 Design	Medium
4	Provision of DoLS Supervisory Body role	3 Design	High
5	Authorisation of DoLS Applications	3 & 4 Operation	High
6	Case tracking	4 Operation	High

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ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2023/24 Plan								
Integrated Performance Framework	Review how the Integrated Performance Framework has been introduced and establish if it is being appropriately utilised to provide effective assurance on the services being provided and commissioned.		Planning, Performance and Commissioning			Final Report	Substantial	October
2024/25 Plan								
Integrated Plan Development Process	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	13	Planning, Performance and Commissioning	1		Final Report	Reasonable	October
Cleaning Standards	Review of processes and controls in place to ensure compliance with national cleaning standards.	21	Finance, Capital and Support Services	1		Final Report	Reasonable	October
Core Financial Systems – Treasury Management	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	15	Finance, Capital and Support Services	2		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
Patient Flow / Discharge Management	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.	6	Primary, Community Care and Mental Health	1		Work in Progress		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		Work in Progress		March
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		Work in Progress		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		March
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		Draft Brief Issued		March
Follow-up: Information Governance	Follow-up of 23/24 Limited Assurance report.	17	Corporate Governance / Board Secretary	3		Draft Brief Issued		March
Business Continuity Planning	Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Following on from the 23/24 audit of the corporate level arrangements.	23	Public Health / Primary, Community Care and Mental Health	3		Final Brief Issued		March
Cancer Services	A review of Cancer Services included for the second half of the plan. Scope could cover the Cancer Tracking Service or Harm Review Process, to be confirmed later in the year.	5	Medical	3/4		Draft brief issued		March
Medicines Management	Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing.	4	Medical	4		Draft brief issued		March
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		March
Risk Management & Assurance	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	1	Corporate Governance / Board Secretary	4				May

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Mental Health Care and Treatment Planning	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.	7	Primary, Community Care and Mental Health	2/3	4			May
Quality & Safety Governance (Duty of Quality)	Review of the implementation and operation of the new arrangements around quality and governance structures and floor to Board reporting. Potentially include a review of the Integrated Quality Report.	9	Nursing, Quality, Women and Family Health	4		Draft Brief Issued		May
Partnership Governance Framework	Review of the development and implementation of the Framework.	12	Planning, Performance and Commissioning / Corporate Governance	4				May
Medical Devices - Mattresses	Review of actions taken to address previous incidents that have occurred within the Health Board around mattresses. Provide assurance on whether revised processes and controls are being applied.	20	Finance, Capital and Support Services	4				May
Site Co-ordination	Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	22	Finance, Capital and Support Services	4				May
Estates Condition Follow-up	Follow-up of 23/24 Limited Assurance report.	28	Finance, Capital and Support Services	TBC				TBC
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.		

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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. To be approved by January 25 ARAC.		

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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

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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	62% 8 from 13	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	90% 9 from 10	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	70% 7 from 10	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 10 from 10	80%	v>20%	10%<v<20%	v<10%

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Assurance Ratings

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Assurance not applicable</p>	<p>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.</p>

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Core Financial Systems – Treasury Management

Final Internal Audit Report

November 2024

Powys Teaching Health Board



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Powys Teaching
Health Board



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Review reference:	PTHB-2425-15
Report status:	Final
Fieldwork commencement:	21 st August 2024
Fieldwork completion:	8 th October 2024
Debrief meeting:	24 th October 2024
Draft report issued:	25 th October 2024
Management response received:	15 th November 2024
Final report issued:	19 th November 2024
Auditors:	Ian Virgill, Head of Internal Audit, Warren Alexander, Principal Internal Auditor
Executive sign-off:	Pete Hopgood, Executive Director of Finance, Capital and Support Services
Distribution:	Hywell Pullen, Deputy Director of Finance Sarah Pritchard, Assistant Director of Finance (Accounting and Services)
Committee:	Audit Risk & Assurance Committee



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

Acknowledgement

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

Disclaimer notice - please note

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

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

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

Executive Summary

Purpose

The overall objective of the audit is to evaluate and determine the adequacy of the systems and controls in place within the Health Board for Treasury Management.

Overview

We have issued substantial assurance on this area.

The matters requiring management attention include:

- The need to ensure that Financial Control Procedures are subject to regular review and updating.
- Bank mandates need to be reviewed to ensure that signatories are up to date and appropriate financial limits are stipulated.

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

Report Opinion

Substantial



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

Low impact on residual risk exposure.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Financial Control Procedure	Reasonable
2 Cash Forecast Production	Substantial
3 Cash Forecast Updates	Substantial
4 Receipts and Payments	Substantial
5 Transfers	Reasonable
6 Bank Account Reconciliations	Substantial

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority	
1	Financial Control Procedure Reviews	1	Operation	Medium
2	Bank Mandates / Account Access	5	Operation	Medium

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1. Introduction

- 1.1 A review of Core Financial Systems was completed in line with the Powys Teaching Health Board's (the 'Health Board' or 'PTHB') 2024/25 Internal Audit Plan.
- 1.2 As part of the 2024/25 Internal Audit planning process, it was agreed that the core elements of the Health Board's financial systems would be subject to review on a cyclical basis. The first area to be reviewed is Treasury Management.
- 1.3 Treasury Management is concerned with the process of managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. There must be effective processes and procedures in place to ensure that all of the Health Board's financial obligations (e.g. the payment of employees and suppliers) can be met without interruption.
- 1.4 Treasury Management includes cash forecasting, cash flow management, receipting and banking controls.
- 1.5 The Executive Director of Finance, Capital and Support Services is the lead Executive for this audit.

2. Detailed Audit Findings

Objective 1: Arrangements for Treasury management are documented within an up-to-date financial control procedure.

- 2.1 PTHB Standing Financial Instructions are available on the PTHB Internet site. The current version specifies a publication date of September 2021 (updated September 2023) but does not specify a future review date. **(Matter Arising 1).**
- 2.2 Comprehensive Financial Control Procedures (FCPs) are in place which provide guidance to staff performing duties in relation to the Health Board's finances. Several of these FCPs are of particular relevance to the Treasury Management functions. For the purposes of this audit, detailed reference has been made to:
 - FCP 005 (Commercial Bank Accounts Control)
 - FCP 017 (Cash Forecasting and Management)
- 2.3 A sample of specifications detailed in selected Financial Control Procedures was selected and cross-checked with relevant sections of the Standing Financial Instructions to ensure no contradictory guidance had been included.
- 2.4 Section 7 of the SFIs (Banking Arrangements) were checked against the recently revised FCP 005 and it was found that the controls specified in the FCP supported the requirements of the SFI.
- 2.5 Section 7.2 of the SFIs lists responsibilities of the Director of Finance in relation to the maintenance of the Health Board's bank accounts. The FCP supports this by specifying that the authorisation of the Director of Finance must be sought in relation to the setting up of accounts, and by setting out reporting requirements.
- 2.6 Section 7.3 states that the Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-

to-day operation of bank accounts and lists eight expected controls. All were found to be addressed in the relevant sections of the FCPs.

2.7 The specifications detailed in FCP 017 address the requirements of the SFIs with respect to cash forecasting procedures. The financial reporting framework prescribed by the Welsh Government (WG) also requires that forecasting procedures are followed. It is likely that any significant deficiencies in this area would result in one or more of the following adverse outcomes:

- An account belonging to the Health Board may become overdrawn;
- The balance of a Health Board account may be insufficient to service payments which become due;
- Interim 'top-up' payments would be required more frequently, or could not be adequately justified, which would likely result in queries from the WG; and
- The balance of a Health Board account remaining at the end of a payment period is unnecessarily high, or a balance accrues incrementally and is not reduced.

2.8 Therefore, whilst procedures in relation to cash forecasting are documented in FCP 017, there are also additional controls relating to the submission of financial information to WG which ensure that accuracy and consistency of reporting is maintained.

2.9 The PTHB Scheme of Delegation document was adopted by the Health Board in July 2021, and was amended in May 2022, May 2023 and September 2023.

2.10 The Scheme of Delegation is principally comprised of a table which lists the requirements of the SFIs and the delegation arrangements which relate to them. This provides some assurance that the contents of the Scheme of Delegation are concordant with the SFIs.

2.11 Oracle requisition limits are specified in the Scheme of Delegation and are as follows:

- Up to £10k - Nominated Budget Holder for Specific Cost Centres
- £1k to £25k - Assistant Directors
- Up to £50k - Executive Directors
- Up to £100k – Chief Executive

2.12 It is unclear why a lower threshold is specified for Assistant Directors only.

2.13 Limits are also specified for expenditure commitments made outside of the Oracle requisition process. These relate to expenditure categories such as pharmacy drugs, pension agency invoices and legal claims. Limits and delegation arrangements were found to be appropriate.

2.14 SFI requirement 9C specifies arrangements for the establishment of bank accounts and that related responsibilities are delegated to the Head of Financial Services. **(Matter Arising 2).**

-
- 2.15 The Financial Control Procedures examined during this audit were in the process of being reviewed. Updated copies that had not been approved at the time of audit were provided for FCP 001 and FCP 005.
- 2.16 Copies of eight out of a total of ten FCP documents currently published on the PTHB intranet site specify an Issue date of September 2015 and a scheduled Review date of September 2018. FCP 010 was issued in March 2017 with a review date specified as March 2020. **(Matter Arising 3)**.
- 2.17 FCP 007 was issued in March 2024 and is not due for review until March 2027. FCP 021 was issued in September 2021 and is imminently due for review (September 2024).
- 2.18 During our enquiries in relation to the FCPs we were informed that in general, very few changes occur which relate to the FCPs and as such, updates are made infrequently.

Conclusion:

- 2.19 Standing Financial Instructions are in place and up to date. Some updates are outstanding with respect to the Financial Procedure Rules and review dates have not been defined. This objective has been given a **Reasonable** assurance rating.

Objective 2: A full year cash forecast is produced in a format consistent with the financial Monitoring returns.

- 2.20 A cashflow forecast covering the current financial year comprises part of the Monthly Monitoring Return Submissions to WG, and as such is updated on a monthly basis.
- 2.21 A total of twelve bank accounts belonging to the Health Board were examined during the course of the audit. Statements for each account covering a four-month period from April to July 2024 were reviewed, and all accounts were in credit at all times.
- 2.22 General guidance in relation to the submission of the Health Board's Monthly Cash Forecast to WG is contained within FCP 017, which is available on the PTHB intranet site. More specific operational guidance has not been produced. **(Matter Arising 4)**.
- 2.23 A 'Welsh Health Circular' containing monthly financial monitoring return guidance and associated submission templates was issued on 20th May 2024. This contains detailed specifications with respect to the financial reporting requirements imposed upon Health Boards by WG.
- 2.24 Monthly cash requests are made by the Health Board to WG using a standard 'Financial Information System' (FIS) spreadsheet. These are required to be submitted 5 working days prior to the end of every month, and contain information with respect to the Health Board's projected income and expenditure over the following month.
- 2.25 Regular monthly submissions for April, May, June and July 2024 were examined, all had been submitted to WG in accordance with prescribed deadlines.

2.26 Monthly Monitoring Returns for April, May, June and July 2024 were also examined and all were submitted in accordance with WG deadlines.

Conclusion:

2.27 Full year cashflow forecasts are produced in a format mandated by the Welsh Government. Monthly cash requests and Monitoring Returns are submitted to WG in a timely manner. This objective has been given a **Substantial** assurance rating.

Objective 3: Regular updates to the cash forecast are made and reviewed, with significant changes being appropriately reported.

2.28 The cash flow forecast is updated as information becomes available or monthly during the production of the Monthly Monitoring Returns for WG.

2.29 Expenditure is monitored by a designated Financial Accountant who uses information from prior periods, creditor balances and other relevant sources of information such as pay award announcements to ensure expenditure forecasts are as accurate as possible.

Conclusion:

2.30 Cashflow forecasts are updated with appropriate frequency and information from relevant sources is incorporated, therefore, this objective has been given a **Substantial** assurance rating.

Objective 4: Receipts and payments are accurately recorded, and Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised.

2.31 The cash flow forecasts are prepared in an established format. Accordingly, there are sections that must be completed which relate to receipts and payments.

2.32 A potential shortfall was identified in April 2024. A higher level of creditor payments than anticipated resulted in the Health Board requesting an additional £3m of funds to be credited on 26th April.

2.33 This request was made to the Welsh Government by e-mail on 12th April, and there is evidence to demonstrate that the Assistant Director of Finance (Accounting and Services) was notified. This measure was shown to be necessary, as the balance of the Health Board's main bank account was approximately £220k when the following scheduled monthly deposit was received.

Conclusion:

2.34 Receipts and payments were found to be accurately recorded, cash balances are regularly reviewed, and cash allocation requests are appropriately requested and authorised. This objective has been given a **Substantial** assurance rating.

Objective 5: Transfers between accounts are appropriately authorised.

- 2.35 Bank mandate change requests were obtained in relation to the Health Board's main Government Banking Service (GBS) account, two Barclays accounts, and eight of the nine Subsidiary Bank Accounts (SBA) belonging to the Health Board's hospitals. Authorised individuals were checked against the NHS Wales directory to verify that they were still live users and that no significant changes to their role had been recorded.
- 2.36 Mandates in relation to the two PTHB Barclays accounts were up to date and appropriate individuals were specified.
- 2.37 With respect to the nine SBAs examined, mandates in relation to two of them authorised individuals who no longer appear to work for PTHB. **(Matter Arising 5)**.
- 2.38 All SBA mandates specified that only one authorised individual was required in order to authorise payments, and authorised limits were noted on only four mandates. The terms detailed in the standard mandate form would appear to indicate that where authorised signatories are not subject to any financial limits, they are by default invested with wide-ranging authority, including the ability to open and close accounts, apply for banking products, enter into agreements and receive information about any account held with the bank. Seven of the mandates examined did not specify financial limits and it would therefore appear that the individuals listed have been granted this authority.
- 2.39 Whilst it is recognised that the SBAs are credited only with very limited funds, thereby providing control over the payments made by the authorised signatories, the additional authorities granted to signatories to whom no financial limits are applied do not appear to be commensurate with the roles of the specified individuals or otherwise necessary for the performance of their duties. **(Matter Arising 5)**.
- 2.40 The bank mandates examined contained details of seven instances whereby authorisations were removed from individuals. One of these instances related to the PTHB Barclays accounts, and six related to various subsidiary accounts. All were correctly authorised.
- 2.41 Account access arrangements relating to the main Government Banking Service account were checked, and it was verified that access rights have been appropriately delegated to senior members of the PTHB Finance team. One individual who no longer works in the Team was listed as having current 'authorisation' and 'view' permissions. **(Matter Arising 5)**.
- 2.42 Three individuals were listed as being able to both input and approve payments, but it was confirmed that the software does not allow an individual to approve a payment that they have input.
- 2.43 Payment authorisation limits were specified on mandate change requests in relation to four of the nine subsidiary accounts. There was e-mail correspondence to indicate that a £250k dual authorisation limit was also applicable to the Health Board's GBS account.

-
- 2.44 Three transfers from the PTHB Barclays Main Account to different subsidiary accounts were examined. All transfers related to petty cash claims and each case was supported by detailed documentation that had been appropriately authorised by the requestor and the PTHB Finance Department.
- 2.45 Unreconciled items in respect of the main PTHB accounts largely consisted of transactions which occurred after the monthly closedown deadline and un-presented cheques. No areas of concern were identified.
- 2.46 It was noted that payments from the SBAs were not always reported promptly, with some remaining outstanding for in excess of 4 months. It is understood that the SBAs are administered much in the same manner as petty cash accounts, in that they are used only for incidental expenditure and funds are replenished as required. (**Matter Arising 6**).

Conclusion:

- 2.47 All transactions examined were appropriately authorised. Some minor control deficiencies were identified in respect of SBAs. This objective has been given a **Reasonable** assurance rating.

Objective 6: Bank account reconciliations are appropriately completed.

- 2.48 Reconciliations of all Health board Bank Accounts are undertaken on a monthly basis. Reconciliations covering a four-month period from April to July 2024 were examined in relation to 12 of the Health Board's Bank Accounts, these included the main Government Banking Service Account, two Barclays accounts, and 9 SBAs belonging to the Health Board's hospitals.
- 2.49 Reconciliations are completed by the Finance Assistant, authorised by the Financial Accountant, and queries or irregularities may be escalated to the Assistant Director where appropriate.
- 2.50 All of the 48 reconciliations examined (12 accounts over 4 months) had been completed and verified appropriately. Values were checked against bank balances and financial ledgers and all agreed.
- 2.51 The combined balances of the SBAs at the end of the period examined (31st July 2024) was £9259.59, the average balance was therefore approximately £1k, and the maximum balance was £2,028 (Bronllys SBA, April 2024).
- 2.52 The Health Board's main GBS bank account was reviewed to ensure expected receipts relating to the monthly FIS form submissions of April, May, June and July 2024, in addition to the supplementary FIS of April 2024 were received. All values matched with the corresponding payment request.
- 2.53 A total of fourteen transactions across the Health Board's principal three bank accounts were selected and checked to source documentation.
- 2.54 Three transfers comprised part of the selection, which are detailed in 2.44.
- 2.55 Eleven further payments of various types were checked. All had been appropriately authorised and were supported by documentation.

2.56 The schedule of unrepresented cheques is updated as part of the monthly bank reconciliation process. As of July 2024, a total of £3,537.89 in unrepresented cheques were listed for the Barclays payments account. Cheque payments are also made from subsidiary accounts, and the values of unrepresented cheques were also included in the reconciliation process.

Conclusion:

2.57 Bank account reconciliations were completed appropriately, suitably verified and adequately documented. This objective has been given a **Substantial** assurance rating.

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Appendix A: Management Action Plan

Matter Arising 1: Standing Financial Instruction Reviews (Operation)		Impact
<p>Whilst it has been noted that the current Standing Financial Instructions were published relatively recently (September 2021), and updated at an appropriate interval (September 2023), a schedule of future reviews is not specified in the document.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Adequate procedural guidance is not available to staff.
Recommendations		Priority
1.1	A schedule of future reviews or details of established review intervals should be included in the Standing Financial Instructions.	Low
Agreed Management Action		Target Date
1.1	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 not be undertaken during that period.	31 December 2024
		Responsible Officer
		Helen Bushell, Director of Corporate Governance

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Matter Arising 2: Outdated References (Operation)		Impact	
Reference is made in the Standing Financial Instructions to the Head of Financial Services. Executive changes within the Health Board have resulted in this role being superseded by the Assistant Director of Finance (Accounting and Services).		Potential risk of: <ul style="list-style-type: none"> Adequate procedural guidance is not available to staff. 	
Recommendations		Priority	
2.1	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).	Low	
Agreed Management Action		Target Date	Responsible Officer
2.1	Agreed - The change to title will be made at next update of Scheme of Delegation scheduled for late 2024.	31 January 2025	Helen Bushell, Board Secretary/ Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

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Matter Arising 3: Financial Control Procedure Reviews (Operation)		Impact	
Ten FCPs with varying degrees of relevance to treasury management were examined as part of this review, and review dates in relation to eight of them had elapsed. Seven of the FCPs had review dates of September 2018. Reviews are currently being undertaken and copies of two updated FCPs were pending approval.		Potential risk of: <ul style="list-style-type: none"> Procedural guidance is out of date. 	
Recommendations		Priority	
3.1	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.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	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 March 2025	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

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Matter Arising 4: Operational Guidance (Design)		Impact	
<p>Limited procedural guidance is available to staff in relation to the cash flow forecasting process. In the context of there being a limited number of individuals involved to any significant degree in the process, this presents risks in terms of business continuity.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Adequate procedural guidance is not available to staff. Welsh Government sanctions. 	
Recommendations		Priority	
4.1	Detailed guidance should be produced in order to document the procedures utilised in the cash flow forecasting process.	Low	
Agreed Management Action		Target Date	Responsible Officer
4.1	Actioned since Audit Fieldwork – Detailed guidance on the cash flow forecasting process has been produced.	Complete	Ian Jackson, Financial Accountant

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Matter Arising 5: Bank Mandates / Account Access (Operation)		Impact
<p>One case of GBS account access permissions, and two bank mandate change requests authorised individuals who no longer appear to be employed by PTHB. No clear review process appears to be in place to provide assurances that account access permissions and bank mandates are up to date.</p> <p>SFI 7.3.1 c) specifies effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error. All authorised signatories of subsidiary bank accounts listed in the mandates examined have been authorised to make payments on their sole authority.</p> <p>Seven mandate updates appear to grant general authority to the nominated signatories, and specifically refers to the ability to open and close accounts. This introduces a risk that FCP005, which specifies 'Any arrangement to set up a bank account relating to PTHB business must be approved by the Director of Finance', is contravened.</p> <p>It is recognised that the SBA accounts are credited only with very limited funds, thereby providing a level of control over the payments made by the authorised signatories and reducing the associated level of risk.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.
Recommendations		Priority
5.1	Account access permissions and bank mandates should be updated to ensure any authorised users/signatories who no longer require authority are removed.	Medium
5.2	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.	
5.3	A list of authorised signatories should be maintained and subject to periodic review.	

Agreed Management Action		Target Date	Responsible Officer
5.1	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 March 2025	Ian Jackson, Financial Accountant
5.2	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 March 2025	Ian Jackson, Financial Accountant
5.3	Agreed - A list of mandate signatories will be defined and subject to regular review	31 March 2025	Ian Jackson, Financial Accountant

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Matter Arising 6: Subsidiary Account Transactions (Design)		Impact	
Unreconciled items in the Health Board's main bank accounts were minimal, with the exception of some transactions which occurred subsequent to the monthly closedowns, and unrepresented cheques. Details relating to payments from the subsidiary bank accounts were reported irregularly, and some transactions remained unreported for extended periods of time.		Potential risk of: <ul style="list-style-type: none"> Unauthorised or fraudulent payments are made. 	
Recommendations		Priority	
6.1	Subsidiary Bank Account Administrators should be instructed to report upon transactions within three months of the original transaction date.	Low	
Agreed Management Action		Target Date	Responsible Officer
6.1	Actioned since Audit Fieldwork – relevant staff members have been emailed to request that all Subsidiary Bank Account returns are undertaken more frequently and as a maximum within a 3-month period.	Complete	Sarah Pritchard, Assistant Director of Finance (Accounting and Services)

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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



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Board & Committee Structure/Effectiveness

Final Internal Audit Report

2024/25

Powys Teaching Health Board



Substantial Assurance

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Review Reference

PTH-2425-02

Fieldwork

September - November 2024

Executive Sign Off

03 December 2024

Audit Committee

January 2025

Executive Lead

Helen Bushell, Director of Corporate Governance/Board Secretary

Audit Team

Ian Virgill, Head of Internal Audit

Lucy Jugessur, Deputy Head of Internal Audit



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Executive Summary

Purpose

To evaluate Powys Teaching Health Board’s (the ‘Health Board’) 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.

Overview

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

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

This review follows on from the previous audit of Board & Committee Structure/ Effectiveness which we completed in 2023/24, and covers the workings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee.

We have concluded **Substantial** assurance on this area. We have identified no key matters for reporting in our review.

Opportunities for Enhancement

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

- Consideration should be given to discussing with Welsh Government the potential of ongoing training and awareness exercises for Independent Members post-appointment, outside that already provided by the Health Board.

Scope & Assurance Summary

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

Findings & Agreed Action Plan

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

Substantial

Overview / Summary of Observations

The Health Board has current Standing Financial Instructions and Standing Orders in place that outline and formalise the Board and Committee governance structures and arrangements, and these were recently reviewed and updated, and approved by the Board in May 2024.

The Board's Terms of Reference (ToR) forms part of the Health Board's Standing Orders and is current in its constitution. All three sampled Committees (Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee) ToR are also current in content having been reviewed and updated and approved by the Board in May 2024.

Additionally, each ToR states the constituent membership, roles and responsibilities of the Committee; and their reporting arrangements, membership quoracy and frequency of meetings to be held.

Our review of Committee meeting structures, and of their respective areas of responsibility as stated within the Standing Orders and Committee ToR documents, confirmed that they were appropriate and did not identify any potential overlap or conflict of subject matter between Committees.

Independent Member Induction and ongoing training/development

The Health Board has an induction process for new members, and provides ongoing support, training and development that enables Independent Members to effectively undertake their roles and management of their respective Committees.

Our discussions with the Committee Chairs of the three sampled Committees identified their satisfaction with the Health Board's induction process, and the regular and ongoing provision of training, development and guidance available to them, and also the support provided by the Corporate Governance Team.

However, we identified that upon completion of the Welsh Government induction process undertaken by Independent Members upon appointment, no further training/awareness is provided to them by Welsh Government. As such, the Health Board should consider discussing with Welsh Government, the possibility of introducing ongoing Independent Member training, outside that already provided by the Health Board, to further enrich their roles within NHS Wales Health Bodies.

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Overview / Summary of Observations

As part of our review, we attended meetings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee. We also met with the Board Chair and Chairs of the aforementioned Committees to discuss their views and approach toward effective Committee management and proceedings

As such, we can confirm that the Health Board Chair and the sampled Committee Chairs effectively manage their meetings and engage with their membership to allow appropriate scrutiny, dialogue, and debate of Agenda items in an efficient manner, in accordance with their prescribed roles and respective experience that they bring to the Health Board.

Additionally, our review of the minutes from a sample of Board and Committee meetings undertaken during 2024/25 demonstrated the scrutiny undertaken, decisions made, and the follow up and confirmation of action completion as appropriate in subsequent Committee Action Plans. This process is supported by an action/issues log tracker spreadsheet for Board and all Committees meetings, and this is accurately maintained by the Corporate Governance Department.

Declarations of Interests

The Corporate Governance Department has a process in place to monitor and manage the annual return of Declarations of Interests, and our testing confirmed that all Board Members and the Executive Team had completed and submitted a Declaration of Interest form for 2024/25.

The Board and Committee Chairs also confirm if there are any specific declarations of interest to be made at the start of each meeting, relating to items included within the individual agendas. Any declarations highlighted through this process would be effectively managed within the meeting to ensure no conflict of interest arises.

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

Substantial

Overview / Summary of Observations

Current Work Programmes are in place for 2024/25 to ensure that the Board and its Committee's annual activity is effectively timetabled, and covers all required areas, as detailed within the Health Board's Standing Orders and the respective TOR.

Our review of the Work Programmes for the Board and the three sampled committees also confirmed that they are aligned to, and provide effective coverage of, the Health Board's strategic objectives and key risks.

Where applicable, deferment or removal of Agenda items are recorded accordingly within the respective Work Programmes.

Our testing of the minutes from a sample of Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirmed that all items stated on their Work Programmes were undertaken as timetabled.

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

Substantial

Overview / Summary of Observations

Our testing of the sample of Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirms that the minutes are accurately documented, and their actions and decisions are clearly delivered. The papers are made available for Board and Committee Chairs and their constituent membership in a timely manner prior to commencement of each meeting.

We also confirm that the agendas, minutes and other papers for these Board and Committee meetings were made available to Health Board staff, the general public and stakeholders for scrutiny, by being published on the Health Board's website in advance of each meeting held.






Our review of the aforementioned Committee meeting cover papers and reports confirm that they are of a high quality, and are detailed and thorough in content, and our conversations with Committee Chairs confirmed their satisfaction in this regard.

Furthermore, our testing also confirmed the submission of each Committee Chair's Update Report to subsequent Board meetings, evidencing the reporting of their key Agenda items and outcomes/actions to be undertaken.

Patterson, Liz
09/01/2025 16:35:11

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.

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

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Public Sector Internal Audit Standards

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Records Management Final Internal Audit Report 2024/25

Powys Teaching Health Board



Substantial Assurance

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Review Reference	PTHB-2425-18
Fieldwork	October / November 2024
Executive Sign Off	06 January 2025
Audit Committee	January 2025
Executive Lead	Helen Bushell Director of Corporate Governance / Board Secretary
Head of Internal Audit	Ian Virgil
Deputy Head of Internal Audit	*****

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Executive Summary

Purpose

Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.

Overview

The Information Commissioners Office (ICO) Records Management Code of Practice 2021 (Section 46) provides guidance to public authorities (and any other organisations whose administrative and departmental records are subject to the Public Records Act) on their obligations in relation to good records management, including keeping, managing and destroying records. Following the code of practice will help the Health Board to comply with the legislation.

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

- There is no fire suppression in the record storage areas.

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

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Appropriate policies, procedures and guidelines are in place for records management, that cover the full lifecycle and ensure standardisation of processes and content.		Substantial
2 Storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.	1	Substantial
3 Physical records are transported and tracked appropriately and are readily available for staff to access		Substantial
4 An appropriate process is in place to archive and dispose of records appropriately, both physical and digital		Substantial
5 The capacity, resilience and succession planning for the records function is appropriate to ensure compliance, recognising the continuing trend of increasing requests for support.		Substantial

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Management Actions

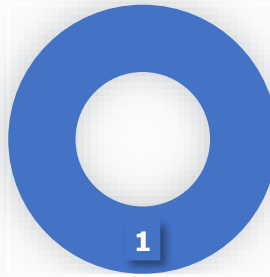


High Priority



Medium Priority

Themes



■ Physical Security



Risk Types

Public Perception & Reputational Risk

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Findings & Agreed Action Plan

Objective 1: Appropriate policies, procedures and guidelines are in place for records management, that cover the full lifecycle and ensure standardisation of processes and content.

Substantial

Overview / Summary of Observations

Powys Teaching Health Board (PTHB) has implemented a framework of policies and procedures to ensure the effective management of records across their lifecycle which has been recently reviewed and enhanced. There is an up-to-date records management policy, together with underpinning procedures which cover both clinical and corporate records which set out clear requirements over all aspects of record management.

Policies and procedures address every stage of the record lifecycle, from creation to final disposal, ensuring authenticity, integrity, and accessibility. Other key documents, such as the Records Management Code of Practice for Health and Social Care 2022 and the Clinical Record Keeping Procedure (IGP 018), reinforce this commitment by setting detailed standards for security, storage, access, and standardisation of records.

Corporate records are similarly governed by specific protocols, aligning with legal and regulatory requirements while maintaining operational efficiency.

Patterson, Liz
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Objective 2: Storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.

Substantial

Overview / Summary of Observations

Our review considered the storage of acute health records. PTHB maintains several locations housing active records, reflecting the geographical spread of the area. Additionally, the Health Board owns dedicated storage facilities for archived records. We note that the Health Board has recently instigated a regular risk assessment review process to ensure their suitability for secure and appropriate record storage.

Approximately 16,000 records, including 160 boxes at Llandrindod and archived records at the Undercroft, are stored in environmentally controlled, secure locations. Access is strictly limited to records staff, with entry controlled by door codes. Records are systematically organised on movable racks, tracked digitally via the Welsh Patient Administration System (WPAS), and older paper logs are integrated at destruction for those not tracked on Intelligent Tracking. Both on-site and off-site facilities are equipped with smoke detectors but not suppression, however we noted no evidence of environmental risks such as water damage.

Comprehensive risk assessments are conducted regularly and logged, demonstrating a proactive approach to safeguarding records and ensuring compliance with best practices with an internal check list used to ensure off site storage is suitable for use. This newly introduced process has already identified several issues, leading to prompt remedial actions. As shown at Knighton, a water leak was identified in a storage area. As a result, the records were immediately relocated, and the room is no longer used for record storage.

Powys Teaching Health Board (PTHB) is also progressing toward a digitisation program, currently in its early stages, aiming to enhance efficiency and security in record management. This will reduce the need for storage of physical records and improve access and security.

Key Finding	Risk & Impact	Agreed Management Action
<p>Although fire detection is in place, there is no fire suppression in records storage areas.</p> <p>Theme: Physical Security</p>	<p>There is the risk of loss of records in the event of a fire.</p> <p>Medium Priority</p> <p>Control Design</p>	<p>The Health Board will consider the feasibility of introducing fire suppression within record storage areas</p> <p>Expected Evidence of Implementation: Copy of SBAR / similar report on feasibility.</p> <p>Officer: Wayne Tannahill, Associate Director of Capital, Estates and Property Date: 31 March 2025</p>

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Overview / Summary of Observations

The Records department follows guidelines which outline the protocols for tracking, securing, and maintaining accountability in the transport of both health and corporate records. They emphasise that original health records must remain on-site at all times, except in cases where explicit authorisation for exceptions is granted. Additionally, a document request form and tracking measures such as WPAS or manual logs are in place to maintain visibility and security throughout the record's lifecycle.

Records are prepared five days in advance of clinics, allowing ample time to address any missing files. There is a defined process for missing files, with temporary files created and the issue reported on DATIX. Extensive searches are conducted to locate missing records, and if unresolved after 12 months, the temporary file is updated and tracked as the active record. The Health Records Procedure ensures temporary files are only created after thorough searches and proper reporting. We note however that due to the tracking procedures in place, there has been no identification of 'missing' records in the last 12 months

The site visit highlighted effective and secure processes for handling and tracking health records. Records are transported in sealed green plastic boxes three times daily (9 am, 1 pm, and 3 pm) by internal drivers, with a detailed contents list for accountability. The Movement of Casenotes procedure ensures records are logged and tracked via the WPAS system, providing traceability and minimising loss risks.

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Overview / Summary of Observations

Powys Teaching Health Board (PTHB) has established a robust procedure for the secure and accountable destruction of physical records, as outlined in the comprehensive IGP 005 Destruction of Records Procedure. This framework, which adheres to the NHS Wales retention schedules for health and corporate records, ensures records are managed and disposed of systematically, with clear steps for verifying status, confirming recent activity, and conducting destruction under confidential conditions.

The process highlights a commitment to accountability, requiring detailed logs of all destroyed records that are integrated into the Information Asset Register, alongside the issuance of certificates of destruction to validate compliance. Departments further contribute to transparency through annual culling statements that document appraised and destroyed materials. While historical culling logs were affected by the blood embargo, measures are in place to compile and maintain these logs moving forward.

Inactive records are efficiently archived off-site after two years of inactivity, with their destruction occurring in strict accordance with retention timelines and procedural standards. PTHB employs Restore Datashred for confidential waste destruction, ensuring adherence to best practices and regulatory requirements.

Patterson, Liz
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Objective 5: The capacity, resilience and succession planning for the records function is appropriate to ensure compliance, recognising the continuing trend of increasing requests for support.

Substantial

Overview / Summary of Observations

Patient Services teams within the Records Department which sits under Planned Care Directorate, plays a key role in managing waiting lists, scheduling appointments, preparing records, and providing audio typing for clinic notes. They collaborate closely with the Information Governance (IG) team to ensure compliance with data protection and confidentiality when processing Subject Access to Information (SARs) requests.

To enhance efficiency, PTHB is conducting a Health Board-wide administrative review, focusing on optimising resources for Band 2-4 roles as part of the Business Efficiencies program. Despite a temporary pause in recruitment for these roles, staffing levels remain stable within both the Records Department and Patient Services teams, with minimal reliance on temporary workers and high retention rates.






The review is exploring process automation to address increasing demands, including a 13% rise in Subject Access Requests (SARs) in 2024. From January 1 to November 27, 2024, the health board received 764 SARs, compared to 675 during the entirety of 2023, with over a month remaining in the year. Managing SARs is a complex, resource-intensive process requiring cross-team coordination. Currently these requests are managed and coordinated by the Information Governance team with the support of local Operational Services SAR representatives.

Mandatory training in Information Governance, Records Management, and Cyber Security is provided to all staff via the Electronic Staff Record (ESR) system, with updates every two years. Specialised training is available for staff involved in SARs to ensure compliance with protocols, and bespoke training is accessible on request. Through a combination of structured training and ongoing support, PTHB equips its staff to uphold high standards of confidentiality and efficiency, aligning administrative practices with its commitment to excellence in patient care.

Patterson, Liz
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Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Staff Retention Final Internal Audit Report

November 2024

Powys Teaching Health Board



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CYMRU
NHS
WALES

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



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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board



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Review reference:	PTHB-2223-11
Report status:	Final
Fieldwork commencement:	16 September 2024
Fieldwork completion:	16 October 2024
Debrief meeting:	04 November 2024
Draft report issued:	28 October 2024
Management response received:	07 November 2024
Final report issued:	08 November 2024
Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Ian Virgill, Head of Internal Audit
Executive sign-off:	Debra Wood- Lawson, Executive Director of People and Culture
Distribution:	Katelyn Falvey, Head of Strategic Workforce Transformation, Planning & Resourcing Julia Williams, Workforce Retention Lead
Committee:	Audit Risk & Assurance Committee



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

Acknowledgement

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

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Executive Summary

Purpose

The overall objective of the audit was to review and assess 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.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Actions within the National Nurse Retention Plan overseen by the task and finish groups do not have revised target dates.
- The Health Board’s local Workforce Retention plan requires completion for use.
- Further work is required to promote the completion of exit questionnaires.

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

Report Opinion



Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 There are relevant plans in place that outline the approach to staff retention	Reasonable
2 Effective initiatives are in place to retain staff and outcomes are reviewed where applicable	Reasonable
3 There is a mechanism in place to collate and learn from information provided at the leavers exit questionnaire	Reasonable
4 There are appropriate governance arrangements in place, which provide an oversight for the regular review and delivery of retention plans.	Substantial

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Setting Milestones for National Nurse Retention Plan actions	1 Operation	Medium
2	Development of Health Board’s Local Workforce Retention Plan	1 & 2 Operation	Medium
3	Exit Questionnaire Completion	3 Operation	Medium

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1. Introduction

- 1.1 Our review of Retention of Staff was completed in line with the 2024/25 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').
- 1.2 Retaining and supporting the workforce to continue to deliver, safe, quality and excellent care is one of the Health Board's priorities.
- 1.3 It is important that both new and existing staff are supported and encouraged to remain with the organisation because a staff member's experience can have a direct and measurable impact on employee's retention.
- 1.4 The Health Board has a higher workforce turnover rate when compared to the NHS Wales average. The organisation has experienced a varied level of staff turnover amongst staff groups within the organisation, with nursing and midwifery having the highest head count.
- 1.5 The Executive lead for this review is the Executive Director of People and Culture.
- 1.6 The potential risks considered for this review were as follows:
 - The Health Board fails to deliver the goals and objectives detailed within its staff retention Plans;
 - The Health Board is unable to consistently operate in a safe manner due to insufficient staff;
 - Lessons learnt from the leavers interview are not captured; and
 - Continued reduction in the Health Board's workforce due to recruitment and retention issues not being monitored and/or corrective action not being taken.

2. Detailed Audit Findings

Objective 1: There are relevant plans in place that outline the approach to staff retention. The Plans set out clear milestones and objectives with specific actions to achieve them.

- 2.1 There is a National Nurse Retention Plan which was published by HEIW in October 2023. The Plan is intended to supplement and strengthen the work that many organisations had already progressed. The plan is supported by a retention guide and a self-assessment tool. The Health Board is required to implement thirty-nine actions across the plan's seven themes, with wellbeing, Welsh language and inclusion threaded through the plan.
- 2.2 The National Plan is owned and led by HEIW, it is nurse specific and was developed before the Health Board's workforce retention lead was appointed. The actions within the plan have a number of responsible owners, these are undertaken by the Health Board, HEIW and the Welsh Government.
- 2.3 The staff turnover rates have been noted as an All-Wales issue and support has been recognised to be needed. The Health Board appointed a new workforce retention lead in February 2024. The role has been funded for two years and the

basis for the role is to review the general workforce retention but specifically focus on nurse retention.

- 2.4 The Health Board is required to report to HEIW against the actions and milestones within the National Nurse Retention Plan. We note that two thirds of the target dates for completion of actions within the plan lapsed just after the Health Board's lead started in post (and at the end of the 23/24 financial year end), also almost one third of the target dates were set for April 2024. This has been raised with HEIW by the various Health Board appointed workforce retention leads. However, it is the expectation that work should still be undertaken within the Health Board to ensure the set actions are undertaken.
- 2.5 Work has been undertaken and is being picked up locally by four task and finish groups named; Experience, Influence, Develop and Flexible. The groups are working on the actions that have lapsed within the National Nurse Retention Plan and some of the more local actions. The groups meet monthly and keep and update their respective action plans and action logs.
- 2.6 Review of the National Nurse Retention Plan actions being taken forward by the task and finish groups, found seven of the thirty-nine actions had been fully completed (as at time of the audit) with evidence provided. However, we note that the remaining actions that have lapsed have not been allocated new targets for completion within the task and finish groups. **(Matter Arising 1 – Medium Priority)**
- 2.7 The Retention Steering Group has responsibility for the development of an organisational local Workforce Retention Plan. At the time of our audit the local plan was in its early stages of development. However, there is need to work towards completing this as the National Nurse Retention Plan makes a number of references to a Health Board local plan, highlighting the importance of its development. **(Matter Arising 2 – Medium Priority)**

Conclusion:

- 2.8 The National Nurse Retention Plan published by HEIW has actions with milestones which though lapsed are required and still being worked on by the Health Board. However, new milestones have not been set for achieving these actions. We also note that there is ongoing work in place to develop a robust local Workforce Retention Plan, which is a reference tool within the National Nurse Retention Plan and a key plan for the Health Board as a whole. We have provided **Reasonable Assurance** for this objective.

Objective 2: Effective initiatives (such as social media, staff engagement, succession planning and staff surveys) are in place to retain staff, they align to agreed plans, and outcomes are reviewed where applicable.

- 2.9 The workforce retention lead has been communicating and meeting with members of staff from the Executive to the Operational level. A number of initiatives have taken place. This has been done by:

- Undertaking staff surveys;
 - Having well-being roadshows; and
 - Having face to face meetings and visiting staff at their workplace.
- 2.10 There is also a Health Board retention resources and managers information site in place. We were informed by the Head of Strategic Workforce Transformation, Planning & Resourcing that this was a work in progress with additions made as they go.
- 2.11 Information gathered in staff engagement was fed back to service leads to implement actions and improve retention in relevant areas. Meetings were set up with senior managers where there were key/ major issues, providing templates and walking through suggested ways to resolve issues and complete the templates. The expectation is that the templates would be completed by October/ November 2024.
- 2.12 At the organisational level, there are ongoing themes being reviewed and individual areas are asked to look at what affects them locally. A number of themes were presented at the steering group and the Workforce & Culture Committee from the various initiatives.
- 2.13 The People and Culture performance report presented in October 2024 highlighted that the staff turnover percentage rate over the last year within the Health Board reduced from 16.23% in August 2023 (14.43% excluding fixed term) to 12.27% in August 2024 (11.73% excluding fixed term). However, this is still significantly above the NHS Wales turnover rate which was 7.2% in June 2024. (Matter Arising 2 – Medium Priority).
- 2.14 To note, due to the nature of Powys Teaching Health Board which includes geography, population demographics and service delivery, it may not be realistic for PTHB to achieve a turnover to replicate the NHS Wales average. However, we recognise that there has been a reduction in staff turnover in recent months which is a positive shift.

Conclusion:

- 2.15 A number of initiatives have been commenced to encourage and improve the retention of staff. Analysis has also been undertaken and the outcomes have been shared with affected areas and reported to the Steering group and the Workforce & Culture Committee. However, the Health Board's staff turnover rate remains significantly above the NHS Wales average. We have provided **Reasonable Assurance** for this objective.

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Objective 3: There is a mechanism in place to collate and learn from information provided at the leavers exit questionnaire. There are actions or systems in place to feed lessons learnt into retention plans and processes

- 2.16 There is a pre-set All Wales NHS leavers questionnaire which consists of ten drop down questions and an open comment section, this is within the Electronic Staff Records (ESR). Where a staff member is leaving the organisation, ESR automatically sends an exit questionnaire which the leaving staff member is expected to complete themselves.
- 2.17 The Workforce Retention Lead receives an Electronic Staff Record (ESR) business intelligence report on a monthly basis from the systems People and Culture team. Areas where the Health Board is performing well or poorly are sighted and themes are drawn from here.
- 2.18 A process of six-monthly reviews of exit questionnaires has commenced, with the first covering the period January to June 2024. Themes are identified through the review based on the weighted responses received and these will be picked up by the respective task and finish groups. An exit questionnaire analysis was presented at the Workforce Retention Steering Group and at the Shared Delivery meeting in which People and Culture colleagues attend. Workforce & Culture Committee will also receive an update in the coming months.
- 2.19 The exit questionnaire completion rate was at 28%, as stated in the exit questionnaire analysis of the January to June 2024 report presented at the Workforce Retention Steering Group in September 2024. Actions have been put in place to improve the rate of completion and ensure they are relevant and reliable, although some of these are currently work in progress. **(Matter Arising 3 – Medium Priority)**
- 2.20 There is an exit questionnaire process guidance which highlights how data/information extracted from the exit questionnaire report should be escalated via relevant mediums to address staff concerns. The guidance is in the process of being finalised. **(Matter Arising 3 – Medium Priority)**

Conclusion:

- 2.21 There is a new six-monthly review process in place used to collate and understand the reasons the staff turnover rate is high. Analysis from the review has highlighted some areas that had previously been flagged as actions. Further work is required to ensure the rate of completion of the exit questionnaires is improved. We have provided **Reasonable Assurance** for this objective.

Objective 4: There are appropriate governance arrangements in place, which provide an oversight for the regular review and delivery of retention plans.

- 2.22 The People Culture performance report is presented at every meeting of the Workforce & Culture Committee as a part of the standing agenda for assurance. It is also presented at Executive Committee.

-
- 2.23 Staff retention has been discussed at Executive Committee and Workforce & Culture Committee. There was a review of workforce retention in the Health Board from April 2023 to March 2024, this was presented in June 2024 and shared at Executive committee and Workforce & Culture Committee.
- 2.24 On a quarterly basis, updates are provided to the Workforce & Culture Committee for assurance against delivery of the Health Board's Integrated Plan. There are themes within the Plan relating to Workforce and OD, these themes are reported every six months.
- 2.25 In March and September 2024, an update on the 'Workforce futures' priority for strategic priority 11: A great place to work' theme was presented, this included an update on the Nurse retention plan.
- 2.26 There is a Workforce Retention Steering Group in place supported by four task and finish groups. The Workforce Retention Lead chairs the Steering group that has members from across the organisation, meets bimonthly and reports into the Executive Committee. The Steering Group has up to date terms of reference, keeps action logs, agendas and minutes of meetings. The three meetings reviewed were all quorate and operated effectively.
- 2.27 Each of the Experience, Influence, Develop and Flexible task and finish groups has a different focus as their name suggests, with work being done to ensure they have a variety of staff voice from clinical and operational colleagues. The task and finish groups provide updates to the steering group at every meeting.
- 2.28 The HB provides six-monthly update reports to HEIW against the National Nurse Retention Action Plan. Following the plan update presented in September 2024 at the Retention Steering Group, the update was also provided to HEIW.

Conclusion:

- 2.29 There are four task and finish groups which report to a Steering Group with responsibilities for undertaking the actions as set within the National Nursing Retention Plan. There are also appropriate overview and governance arrangements in place for staff retention at a Health Board level via the Executive Committee and the Workforce & Culture Committee. We have provided **Substantial Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Setting Milestones for National Nurse Retention Plan (Operation)			Impact
<p>The Health Board is required to report against the actions and milestones within the National Nurse Retention Plan. We note that the actions stated within the national retention plan have passed their original target dates. However, the task and finish groups do not have an updates timeline for the delivery of the national retention plan actions.</p> <p>Anticipated end dates and latest updates of progress towards the completion of the Nurse Retention Plan actions are not entered into the action plan which is presented at each of the Task and finish groups meetings.</p> <p>We also note that 8 of the 39 actions within the plan had not commenced at the time of the audit.</p>			<p>Potential risk of:</p> <ul style="list-style-type: none"> Task and finish groups and Health Board as a whole are unable to decide where or what to place priorities on as there are no target dates set.
Recommendations			Priority
1	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.		Medium
Agreed Management Action		Target Date	Responsible Officer
1	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.	January 2025	Julia Williams, Workforce Retention Lead

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Matter Arising 2: Development of Health Board's Local Retention Plan (Operation)		Impact	
<p>The Health Board's local Workforce Retention Plan commenced development in June 2024. We note that the Health Board is focusing on its priorities as they align to the nurse retention plan, ensuring they are applicable to the Health Board. The workforce retention lead is working on the organisational plan, but this still requires further work to be done. Additional details of measures to achieving the milestones such as areas to identify, areas to improve on and setting targets dates for actioning are required.</p> <p>The workforce retention lead has also been communicating and meeting with members of staff from the Executive to the Operational level to discuss staff retention. Actions have been developed at a local level following this engagement and on an organisational level, there are ongoing themes being reviewed. A number of themes were presented at the Steering Group and the Workforce & Culture Committee from the various initiatives.</p> <p>However, we note that the Health Board's staff turnover rate of 12.74% in August 2024, remains significantly above the NHS Wales average.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> The Health Board fails to deliver the goals and objectives detailed within its staff retention Plans. 	
Recommendations		Priority	
2	<p>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.</p> <p>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.</p>	Medium	
Agreed Management Action		Target Date	Responsible Officer
2	<p>Develop the Workforce Retention Improvement Plan for Powys Teaching Health Board and gain Executive sign off prior to implementation.</p>	March 2025	Julia Williams, Workforce Retention Lead

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Matter Arising 3: Exit Questionnaire Completion (Design / Operation)		Impact
<p>The six-month review of the exit questionnaires undertaken from January to June 2024 highlighted a completion rate of 28%. In order for the Health Board to be able to derive benefits from the information provided therein, the completion rate needs to be improved.</p> <p>We note that the following actions are currently being put in place:</p> <ul style="list-style-type: none"> • A staff communication is being put in place. This is currently a work in progress; • Posters are currently being developed; • We were informed that information around the need to complete the exit questionnaire is to be included in the local management training programme, corporate induction and passed on to relevant groups as well. The team which run the Health Board’s Manager’s programme stated that the completion of exit questionnaires is verbally mentioned in the programme; and • Production of an exit questionnaire process guidance. This is in the process of being finalised. 	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Health Board is uninformed on the reason for a high turnover rate. • Learnings from leaver not captured. 	
Recommendations		Priority
<p>3.1 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.</p> <p>3.2 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.</p> <p>3.3 The exit questionnaire process guidance should be finalised for use by the Health Board.</p>	<p>Medium</p>	

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Agreed Management Action		Target Date	Responsible Officer
3.1	Complete development of manager and employee information around exit questionnaires and communicate this with all staff through a multi-modal communication plan	January 2025	Julia Williams, Workforce Retention Lead
	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.	March 2025	
3.2	Ensure exit questionnaire relevance and importance is included in programme of education within the PTHB Managers Programme and Corporate Induction.	December 2025	
3.3	Finalise the process for escalation of exit questionnaire data and publish on PTHB Sharepoint.	January 2025	

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Capital Systems

Final Internal Audit Report

2024/25

Powys Teaching Health Board



Reasonable Assurance

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Appendix A 11

Review Reference

PTHB-SSU-2425-26

Fieldwork

July - September 2024

Executive Sign Off

19 November 2024

Audit Committee

9 January 2025

Executive Lead

Pete Hopgood

Head of Internal Audit

Huw Richards

Deputy Head of Internal Audit

Eifion Jones

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Executive Summary

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Internal Audit Plan. Capital systems coverage during 2024/25 focussed on the selection, appointment and contractual arrangements applied at Capital and Estates projects (covering both advisers and contractors).

Overview

Over the past few years, Capital and Estates have dedicated substantial time and effort to developing a structured control environment for their projects. This commitment has involved implementing a capital toolkit designed to enhance project management and oversight. By establishing clear processes and standards, the department has aimed to ensure consistency and quality across all projects. Whilst good compliance was noted in most areas, there were some matters that required further management attention e.g.:

- Developing appropriate contract strategies to ensure consistency in the contracts utilised and executed.
- Reviewing the capital procedures to ensure document retention criteria associated with construction contracts is appropriately defined.
- Standardising the level of detail in the procurement strategy for individual projects.
- Establishing mechanisms to track and monitor areas for improvement identified within the annual procurement reports.

Full detail of these matters is provided within the Findings & Agreed Action Plan. Additionally, the following opportunities for enhancement have been identified, which do not impact the overall opinion but are highlighted for management information:

- Horizon scanning for changes to procurement rules due to take effect from February 2025 and assessing how these may affect current operational processes.
- Exploring opportunities for training related to the upcoming changes to procurement rules.

We have concluded **reasonable assurance** in this area.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Governance - To assess the application of appropriate procurement policies and procedures to Capital and Estates contracts and ensure that roles and responsibilities and approval requirements were adequately defined.	-	Substantial
2 Contract Completion - To obtain assurance on the timely completion, recording, and approval of agreement/ contract versions in accordance with the approved contract strategy (with appropriate inclusions and clauses).	1	Limited
3 Selection and Appointment - To ensure the appropriate application of Standing Orders, Standing Financial Instructions (SFIs), national and local procurement policies for the selection and appointment of contractors and technical advisers. To ensure the application of appropriate competitive	2,3	Reasonable

	tender/quotation arrangements, the use of frameworks (as applicable) and the appropriateness of associated management and reporting.		
4	Value for Money and Award – To ensure that there was an appropriate assessment of value for money (e.g. via tendering/ quotation, benchmarking etc), with formal recommendations for award. Appropriate approvals were in place, that fully considered the above and any associated limitations.	1,2	Reasonable
5	Retention of contract and project documentation - To obtain assurance that Capital and Estate’s contract information was retained for the requisite period (in accordance with national guidance) and that all contract documentation was held securely.	4	Reasonable

Management Actions



High Priority



Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk

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Capital Systems - At a Glance

Purpose

A total of 10 projects were sampled for this audit covering a range of financial years, values and funding sources as follows:

Project title	Financial Year	Project Total Cost (£)	Funding Mechanism
Courtyard Refurbishment, Bronllys Hospital	2023/24	65,000	Discretionary
Park Offices Enabling Works	2023/24	135,000	Discretionary
Refurb of Podiatry – Welshpool Hospital	2023/24	35,000	Discretionary
Bungalow 3 Refurbishment Bronllys Hospital	2024/25	35,000	Discretionary
Llanidloes Hospital, Staff Room	2024/25	45,000	Discretionary
Electrical Substation Capacity Upgrade, Welshpool Hospital	2023/24	372,600	Estates Funding Advisory Board
Waste Compliance	2023/24	12,060	Estates Funding Advisory Board
Ystrad Solar PV	2024/25	300,000	Estates Funding Advisory Board
Bronllys Hospital, Roofing	2023/24	1,480,000	All Wales Capital Programme
Bronllys Hospital, Car Park	2024/25	250,000	All Wales Capital Programme

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Findings & Agreed Action Plan

Objective 1: Governance Arrangements

Substantial

The Teaching Health Board (THB) adopted the NHS Model Standing Orders, Reservation, and Delegation of Powers in July 2021, with the latest amendments made in September 2023. The Scheme of Delegation – Standing Orders Schedule detailed requirements for approval of capital schemes funded through discretionary allocations. The THB's Capital Procedures, approved by the Innovative Environment Group in September 2023, outlined clear ownership and accountability requirements. Updates to the Capital Procedures Reviews were linked to lessons from previous audits and post-project review documentation. This was seen as a positive practice.

The THB also used a capital booklet to provide guidance and ensure a standardised approach to project management. This booklet includes various forms and documents to be completed throughout the project lifecycle, broken down into stages for ease of completion. Additionally, the Capital and Estates department maintained an annual declaration of interests, which were logged centrally and categorised by roles, including the Capital Team, Estates Team, and admin teams. This structured approach helped maintain transparency and accountability within the department.

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Objective 2: Contract Completion

Limited

The THB's SFIs section 11 set out the procurement thresholds for capital projects, including the form of contract to be adopted. The THB's Capital Procedures reference the need to comply with the SFIs, however there was no detailed contract strategy as to how this was to be implemented at an operational level. This led to an inconsistency in approach at the individual projects sampled, whereby four projects had no contract in place.

By ensuring that a comprehensive and tailored contract strategy is in place, management will better position the THB to deliver successful outcomes across its programmes and services, while maintaining accountability, financial control, and quality assurance.

Where contracts were in place, they were appropriately signed and included key clauses such as:

- Rectification periods.
- Sectional completion.
- Liquidated ascertained damages.

These clauses were essential for maintaining project integrity and ensuring liabilities were well-understood.

Key Findings

Risk & Impact

Agreed Management Action

1

Contract Strategy

SFIs section 11 outlines:

Lack of adequate legal protection and accountability, which can lead to disputes, cost overruns, project

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 procedures were signed off at Innovative Environments Group on 8 November 2024.

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Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Form of Contract
<£5,000	Purchase Order
>£5,000 - <£25,000	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Formal contract and Purchase Order
>OJEU threshold	Formal contract and Purchase Order

delays, and quality issues.

Expected Evidence of Implementation:

- Capital Procedures updated and signed off at Innovative Environments Group 8 November 2024
- Reference booklet CP4.3 Capital Strategy

Capital Procedures section 4 reference the need to comply with the above table. However, there was no detail as to how this would be implemented.

The audit sampled 10 projects above £5000, purchase orders were in place for all projects sampled. However, there was an absence of formal contract documentation at 4 projects. For example, at the Bronllys Courtyard Refurbishment £78,034, the Joint Contracts Tribunal (JCT) minor works contracts were intended to be used; however, no contract was implemented - no explanation or justification for this variation was documented.

Where contracts had been utilised, there were also variations within the contract types e.g. JCT versus New Engineering Contracts (NEC) for contractors.

High Priority

Officer: Head of Capital
Date: November 2024

Theme: Contractual

Control Design

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Compliance with SFIs and procurement regulations were observed when selecting contractors/advisers. Monthly meetings between the THB and NWSSP Procurement Services reviewed pipeline projects, resource needs, and other associated project issues, which was considered positive practice.

Various procurement routes were utilised at our sample of 10 projects, including open tender, single tender action, and utilisation of various national frameworks. Documentation was appropriately maintained with positive engagement undertaken by Estates and Capital staff with NWSSP Procurement Services. The single tender action process was appropriately applied at the one instance observed. However, inconsistencies were noted at the procurement strategies within the respective Project Initiation Documents. For example, when frameworks were used, the rationale for direct awards versus mini competition was not always clearly documented. Both methodologies were permitted under the framework, but clear documentation was necessary to demonstrate that value for money was achieved.

Monitoring and reporting processes were clear, with an annual procurement activity report provided by NWSSP Procurement Services and reviewed by the THB's Innovative Environments Group (latest report 2022/23 as delays had been noted for the 2023/24 version). However, improved tracking and monitoring was needed of the action/improvement areas noted within the report.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 Consistency in Procurement Strategy approach</p> <p>A key document to be completed was the Project Initiation Document (Form CP2.1), with Section 5 dedicated to outlining the procurement strategy to be applied at individual projects.</p> <p>From the sample of 10 projects, the detail provided within the procurement strategy section varied significantly. For example, one contained extensive information on compliance with the SFIs through competitive tendering. In contrast, another simply stated that a contractor would be appointed using the Welsh Procurement Alliance framework, without further explanation on how Value for Money would be attained. In the latter instance, there was no explanation of whether a mini-competition or direct award would be applied, nor any rationale provided to justify the selected approach.</p>	<p>Inconsistencies in approach could potentially lead to not optimising supplier selection and less value for money being achieved.</p>	<p>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 reduction on the published rates. An explanation of where/why the optional mini tender process was implemented or not will be recorded in the PID, form 2.1.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Suitable completion of the Procurement Strategy form in the PID. <p>Officer: Head of Capital Date: November 2024</p>
<p>Theme: Planning, Delivery & Deadline Management</p>	<p>Medium Priority</p> <p>Control Operation</p>	

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3	<p>Monitoring and Reporting</p> <p>Annual procurement activity reports had been produced for 2021/22 & 2022/23 that documented e.g.</p> <ol style="list-style-type: none"> 1. Quotation Activity Schedule and Conformance Review. 2. Tender Activity Schedule. 3. Single Tender Waiver Activity Schedule. 4. Areas for Action / Improvement. <p>However, there had been a delay in producing the 2023/24 report, accordingly it was not available for review. The audit did not identify any formal tracking or monitoring of any improvement areas identified at the 2022/23 report.</p> <p>The reports could be improved by providing a year-on-year comparison of supplier spending e.g. there was no cumulative comparison of awards from frameworks, which could increase assurance.</p>	<p>Improvements to procurement processes may not materialise due to lack of proactive monitoring.</p>	<p>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 meetings.</p>
			<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Action Tracker developed which will be a fixed agenda item for the Estates / NWSSP Procurement meetings
		<p>Medium Priority</p>	<p>Officer: Associate Director Capital, Estates and Facilities Date: November 2024</p>
	<p>Theme: Reporting</p>	<p>Control Design</p>	

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Within our sample of projects, appropriate pre-tender estimates had been prepared prior to market testing. This process ensured that a baseline cost estimate was obtained; these costs were included within the project request forms that were reviewed/ approved at the THB's Capital Control Group. This is seen as positive practice and contributes to the setting of realistic financial expectations and for future benchmarking, thereby facilitating effective financial planning.

Following market testing, technical and financial vetting was conducted to ensure that all potential contractors met the necessary standards. This vetting included checks such as public liability insurance, waste carrier licenses, and other relevant certifications. These measures were key to mitigating risks and ensuring that only qualified and compliant contractors were considered. Formal adjudication reports, detailing the evaluations undertaken and the recommendations for awarding contracts, were prepared and signed off at an appropriate level within the THB. This formal process ensured transparency and accountability in the decision-making process.

However, key findings 1 and 3 have an impact on demonstrating effective value for money arrangements. These findings should be referenced when considering the assurance rating of this objective, as they provide evidence supporting a reasonable assurance rating.

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Management advised that significant record retention improvements have been made, largely due to the implementation of a standardised approach to managing project files. By adopting this method, good consistency/ quality of documentation was observed across all projects sampled - streamlining the process of tracking project progress and demonstrating compliance; but also enhancing transparency and accountability.

Contracts that were in place (at 4 of the 10 sampled projects) had been stored in lockable cabinets, ensuring they were secure yet easily accessible to respective project managers when needed. However, it was noted that neither the Capital (nor other) Procedures documented the retention periods adopted within the THB's Information Governance procedures. This omission means there was no clear guidance on how long construction contracts should be retained, which could lead to premature disposal of contractual documents.

Key Findings	Risk & Impact	Agreed Management Action
<p>4 Document Retention</p> <p>Corporately, the THB has adopted the Records Management Code of Practice for Health and Social Care Guidance as part to the destruction of records procedure – requiring that contracts are held for 6 years prior to disposal.</p> <p>The Capital Procedures make no reference to document retention, or the nuances associated with construction contracts executed as a deed/under seal. e.g. the extended liabilities periods of 12 years (as a minimum) or the lifetime (or disposal) of associated buildings.</p> <p>Other potential amendments to Capital Procedures include:</p> <ol style="list-style-type: none"> 1. Changes to threshold for the new NHS Building for Wales Framework. 2. Potential updates with regards to the new procurement regulations (currently effective February 2025). This may include further engagement with NWSSP Procurement Services. 3. Wider publication via the Health Board's SharePoint site. <p>Theme: Policies & Procedures</p>	<p>Clear documentation of retention periods should minimise any potential risk of lost information.</p> <p>Medium Priority</p> <p>Control Operation</p>	<p>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, 12 years, etc.) visit the Project File to abstract elements which <i>could</i> be deemed to be eligible for destruction, particularly as this would need to be undertaken at a management level.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • 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 <p>Officer: Head of Capital Date: November 2024</p>

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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 presents 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 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 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.



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Energy Management

Final Internal Audit Report

2024/25

Powys Teaching Health Board



Reasonable Assurance

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Review Reference	PTHB-SSU-2425-25
Fieldwork	July - September 2024
Executive Sign Off	5 th December 2025
Audit Committee	9 th January 2025
Executive Lead	Pete Hopgood
Head of Internal Audit	Huw Richards
Deputy Head of Internal Audit	Eifion Jones

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Executive Summary

Purpose

Noting rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit.

Overview

The Teaching Health Board’s (THB’s) energy consumption represents 2.3% of the NHS Wales total, with costs of circa £1.0m for gas and circa £1.0m for electricity reported for 2023/24.

Energy is procured centrally on behalf of NHS Wales by NWSSP: Procurement Services, with new contractual arrangements in place from October 2023.

Appropriate governance arrangements were in place, including an experienced Environment & Sustainability Team, reporting into the Environment and Sustainability governance structure.

We evidenced that the Environment & Sustainability Team had established robust systems for data capture, validation and payments: ensuring that management received comprehensive, accurate and timely data for review.

The THB is in the process of utilising re-fit monies of circa £4m to introduce or upgrade Building Management Systems (BMS) e.g. introduction of BMS at Welshpool Hospital and upgrade at Newtown Hospital.

The move to the new NHS Wales energy contract in 2023 had encountered some issues, including difficulties in providing accurate energy forecasts to participating organisations, and additional resource has been required from within the Energy Team to resolve account queries. Recognising the robust data processes operated at the THB, the impact of the national issues had not been as significant as seen elsewhere.

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

- Enhancing energy issue reporting through the inclusion of pertinent WEOG/WEG updates.
- Maintaining appropriate THB attendance at the all-Wales Energy group meetings (WEOG/WEG).
- The conducting of site walk-arounds as recommended by HTM07-02 Encode (Part A section 3.5)
- Consideration of additional energy risks for inclusion on the Estate’s Risk Register.

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

Scope & Assurance Summary

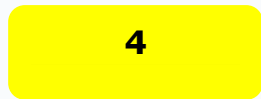
Objectives	Related Findings	Assurance
1 Governance - Assurance that key roles had been assigned and responsibilities of key staff were understood. An appropriate forum had been assigned with responsibility and accountability for overseeing Energy efficiency/ consumption.	1	Reasonable
2 Contract- Recognising the national contracts in place, to obtain assurance that the Health Board obligations under the national contract arrangements were fully understood and applied.	2	Reasonable
3 Data Capture – To ensure that appropriate systems were in place to capture data on energy consumption in a timely manner.		Substantial

4	Data Validation – To confirm adequate checks were undertaken to verify the quality/ reliability of the data – with any anomalies fully investigated.		Substantial
5	Monitoring and Reporting - To review internal / external monitoring and reporting arrangements, to ensure that anomalies were understood, benchmarking was undertaken where appropriate, and any resulting management action was appropriately tracked.	3	Reasonable
6	Energy Awareness - That appropriate training had been established for general and key energy staff focused on increasing awareness of obligations and requirements. Assessment of any other initiatives established to increase awareness e.g. intranet pages, staff circulars, team briefings etc.		Substantial
7	Payments - Energy related billing was verified, authorised, and processed in accordance with contractual payment terms.		Substantial
8	Risk Management - A review of the systems and controls in place to manage energy-related risks, and assurance that risks were escalated as appropriate – to include evaluation of risk mitigation strategies, ensuring compliance with regulations, and addressing any risk exposure.	4	Reasonable

Management Actions

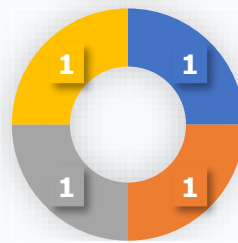


High Priority



Medium Priority

Themes



- Communication & Engagement
- Finance Management & Control
- Governance
- Risk Management

Risk Types

- Financial Loss
- Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: Governance Arrangements

Reasonable

Overview / Summary of Observations

Powys THB does not have a dedicated energy team. However, various individuals within the organisation, particularly those within the Environment & Sustainability Team, handled energy-related responsibilities. This team fulfils many obligations, such as attending and engaging in Welsh Energy Operational Group (WEOG) meetings, liaising with energy suppliers, collating and analysing energy consumption data, and providing reports on usage for both internal stakeholders and external bodies, including NWSSP: Specialist Estates Services and Welsh Government.

Energy performance was reported by the energy team during the monthly Buildings and Biodiversity Group meetings, a sub-group of the Environment and Sustainability Group (ESG). Although Powys THB does not have a dedicated energy forum, as the organisation does not believe its size warrants one, the Buildings and Biodiversity sub-group includes a standing agenda item on energy.

A review of the meeting minutes from January to June 2024 demonstrated that updates from the Buildings and Biodiversity Group were a standing agenda item. These updates were provided verbally by the Chair of the BBG, together with a 'Compliance Highlight Report,' which detailed key risks and actions required related to energy and water

Key Findings

Risk & Impact

Agreed Management Action

1 Energy themed reporting

The Buildings and Biodiversity group meetings include a standing agenda item covering energy. This included a verbal update on energy issues and discussion within the group. The periodic presentation of a report detailing energy usage across the estate was also noted

This in turn was reported through the ESG with an update from the Chair of the BBG and the submission of a Compliance Highlight Report.

All the above are indicative of an established and functioning reporting process, contributing to good overall governance. It was noted however that this could be enhanced by the inclusion of an update from those attending the WEOG meetings of key issues and salient points of interest to PTHB.

Gap in a shared overall understanding of energy issues, in particular contractual which may include risk to the HB from both a financial and supply perspective.

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 required.

Expected Evidence of Implementation:

- Agenda and minutes of Utilities Management Group.

Medium Priority

Officer: Environmental and Sustainability Manager.
Date: November 2024

Control Operation

Theme: **Governance**

Overview / Summary of Observations

In October 2023, the THB entered a new all-Wales NHS energy contract with Crown Commercial Services (CCS), managed by NWSSP: Procurement Services. This change was due to the existing supplier exiting the market, citing volatility since 2021.

Two new central governance forums were initiated to oversee the arrangements:

- Welsh Energy Group (WEG) – Responsible for the strategy for energy procurement and determining basket choices from the CCS framework. Membership included Directors of Finance representing each organisation.
- Welsh Energy Operational Group (WEOG) – Responsible for establishing a common model for supplier management. Membership included operational energy and finance colleagues from member organisations.

Internal Audit reviewed these arrangements in January 2024, determining Substantial Assurance.

The implementation of the new CCS contract has seen issues across NHS Wales, both in the closure of the British Gas accounts and the commencement of relationships with the new gas and electricity suppliers under the CCS framework. These difficulties have impacted all organisations, to varying degrees, e.g. the availability of accurate data (forecasting and validation of invoices) and input of additional resource to resolve issues.

Handover issues were addressed centrally by WEOG. THB’s active participation in WEOG meetings ensured they influenced decision-making and supplier management effectively.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 Attendance at WEOG and WEG meetings</p> <p>Whilst the THB has on the whole been well represented at WEOG and WEG meetings held in the past 10 months, with good engagement noted from those in attendance from the THB, there were a small number of occasions where finance representation was not observed.</p> <p>This is more of a concern at the WEG meetings where opinions are canvassed and decisions made regarding contracts, and the corresponding financial and service implications.</p>	<p>The THB do not have the requisite level of staff attendance at WEOG/WEG meetings, resulting in the THB not being represented in potentially key decision-making discussions.</p>	<p>Management Action:</p> <p>PTHB Environment and Sustainability represent the organisation at the Wales Energy Operational Group. Finance will provide representation at Welsh Energy Group (WEG) meetings where decisions with financial implications are made.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Finance attendance at WEG meeting week commencing 18 November 2024. <p>Officer: Finance Business Partner Date: November 2024</p>
<p>Theme: Communication & Engagement</p>	<p>Medium Priority</p> <p>Control Operation</p>	

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Overview / Summary of Observations

The THB's Environment & Sustainability Team maintained a utility spreadsheet populated manually on a monthly basis with data received from suppliers and independently from manual meter reads. The established processes guaranteed that a comprehensive data set was available for input into the energy management system, facilitating prompt and precise reporting for various objectives, such as financial budgeting. Nevertheless, the dependency on manual data gathering and entry was not considered time efficient.

Whilst there was some degree of sub-metering at the larger sites, this was limited, and data analysis tended to be at site level unless specific concerns required the energy team to investigate a specific meter. Management advised that it was not affordable to change the sub-metering arrangements, reliance was therefore on the BMS systems for more detailed monitoring.

Noting some THB premises were leased to third parties (predominantly other NHS organisations), the THB had an established process to recharge utility costs in an agreed apportioned manner.

The THB were in the process of utilising re-fit monies circa £4m to introduce or upgrade BMS e.g. introduce BMS at Welshpool Hospital and upgrade at Newtown Hospital. This would improve monitoring capabilities and was anticipated to positively impact energy consumption levels.

Overview / Summary of Observations

The THB lacked dedicated software for managing energy consumption data, setting it apart from other NHS organisations in Wales. This however is understandable given the size of the organisation and uniqueness amongst the other Health Boards in not operating larger district general hospitals.

However, the spreadsheets as maintained had been established for several years, with the small estates team fully conversant with their application. Audit testing did not identify any obvious errors at the operation of the spreadsheets. Reliability of data was very much based on the experience and vigilance of the team member (s) maintained the relevant spreadsheet.

The THB also demonstrated a robust authorisation process for the approval of utility invoices prior to their submission to NWSSP for payment. The sample of invoices reviewed having been digitally stamped with payment account numbers, and signatures; checked and authorised appropriately by the two recognised signatories. Also noting the signatories routinely sample the invoices received and check before approval.

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Overview / Summary of Observations

The audit included two site visits, to Newtown and Welshpool Hospitals to assess for any visible instances of energy inefficiency. General good practice was observed at both sites.

At the time of review, limited BMS controls were operating across the THB estate, for example there was a limited function BMS capability at Newtown and Bronllys hospitals and no BMS capability at Welshpool hospital. Installing/ updating the BMS was a specific action included within the THB’s Decarbonisation Action Plan. The THB were in the process of utilising re-fit monies (circa £4.2m) to address the same.

The energy team generated monthly energy consumption reports for individual sites using excel. These were distributed and displayed on site noticeboards. However, the lack of sub-metering limited the granularity of insights. It was noted that the THB, in consultation with colleagues at other Health Boards, will be seeking to utilise more advanced reporting functionality through the adoption of additional custom excel reporting features.

The THB conducted six facet surveys in early 2024, there were also annual mandatory DEC reviews completed along with ISO14001 annual audits. Whilst noting the assurance these provide; energy walk arounds as recommended within HTM 07-02 Encode Part A were not currently undertaken.

With the support of NWSSP SES, the THB has made efforts to gather meaningful benchmarking data, including comparisons with wider health organisations in rural areas of England. However, no relevant comparable organisational data has been identified thus far.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 Site walk arounds</p> <p>Site walk-arounds are recommended by HTM07-02 Encode (Part A section 3.5). The guidance notes that these should be undertaken at least once per year, or ideally once in the summer and once in the winter. These walk arounds not only allow first hand observation of where energy is being used but also offer an opportunity to raise the profile of energy awareness with Health Board colleagues.</p> <p>This is particularly pertinent for PTHB, as understandably, resources, structure and geographical spread of the organisation mean that having dedicated energy champions in post at various locations is not feasible.</p>	<p>Visible matters of energy inefficiency are not identified.</p>	<p>Management Action:</p> <p>‘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 back to the Utilities Management Group where actions will be allocated and monitored.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Audit Plan with energy audits commencing November 2024
<p>Theme: Financial Management & Control</p>	<p>Medium Priority Control Operation</p>	<p>Officer: Environmental and Sustainability Manager. Date: November 2024</p>

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Overview / Summary of Observations

In assessing energy awareness measures, it is recognised that the Decarbonisation agenda (separately audited in 2023/24) now encompasses targeted activity for staff communication and training. The Decarbonisation Action Plan (DAP) and progress against the same has not been re-audited at this review.

The THB do not have dedicated Energy Champions, lacking the available resources to fulfil this extra obligation. However, the THB seeks to address this indirectly with their recognised focus on environment & sustainability.

It was noted that the THB had a well-established commitment to meeting environmental and sustainability targets, with an established DAP in place. The THB has a hierarchy of environmental oversight through groups such as the ESG, BBG and the Innovative Environments Group, the latter of which feeds directly into the Finance and Performance Committee (a subcommittee of the Board).

Whilst energy-related training modules were available on ESR, it was noted that these were not mandatory. This issue was previously addressed at the Decarbonisation Audit conducted in 2023/24, where it was noted that staff take-up of the module had been low. However, acknowledging that the THB through its ESG meeting was seeking to target improvements in this area, acknowledging that improved staff training would better inform future decision making in relation to energy awareness/ promotion.

Overview / Summary of Observations

Audit testing identified a robust process of invoice review, data input and validation by the Environment & Sustainability team. All invoices sampled for testing were confirmed to have been correctly entered into the THB's energy spreadsheets (excel). All received invoices were electronically annotated to ensure they were reviewed and approved for payment.

Individual invoices were processed against an annual call-off purchase order recorded in Oracle at the beginning of the year, which was based on the THB's projected energy costs.

The THB had not incurred any late payment fees in the period reviewed as part of this audit. Testing noted that invoices were processed promptly and sent onto AP within a few days of receiving.

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Overview / Summary of Observations

The latest Corporate Risk Register, as reported to the Board in September 2024, was reviewed for any reference to energy risks. The following were noted:

- Corporate Risk Register (CRR09) noted the risk that *“The care provided in some areas is compromised due to the health board’s estate not being fit for purpose”*. This risk was assessed as having a risk rating of ‘16’ includes achieving the DAP with limited resource.
- CRR 01 - Financial sustainability risk, may contain some element of energy costs, though not explicitly detailed (currently scored 16).
- CRR 011 - National power outage (risk rated as 20). This is a national level risk included by all public sector organisations.

Aside from being reviewed and approved at the Board the Corporate Risks as identified are an agenda item at the respective board sub-committees with responsibility for individual risk areas. For CRR09 this was the responsibility of the Delivery & Performance Committee.

Energy risks that could affect the DAP were reported to, and overseen by, the Buildings and Biodiversity subgroup, the Environment & Sustainability Group and ultimately the Innovative Environments Group.

At a divisional level the Estates Department risk register included a risk (3) ‘Fit for Purpose Estate’ which primarily addresses the availability of capital and revenue funding and the risk to the THB in meeting its objectives; narrative added in a review in March 2024 noted the risks posed by rising energy costs.

Key Findings	Risk & Impact	Agreed Management Action
<p>4 Energy Risk Reporting</p> <p>It was recognised that risks pertinent to energy management measures were captured as part of the Decarbonisation Programme (DAP) governance process. Additionally, there was narrative within the Estates risk register noting Energy cost pressures as part of revenue implications for estates.</p> <p>However, whilst noting the same, during the audit, a number of energy management related risks had been noted and discussed that may warrant formal assessment, including the new All-Wales energy contract, which continued to cause disruption to process and available data.</p>	<p>If not identified and assessed, risks may not be appropriately managed.</p>	<p>Management Action:</p> <p>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 required.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Agenda and minutes of Utilities Management Group.
<p>Theme: Risk Management</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Environmental and Sustainability Manager. Date: November 2024</p>

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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.

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

Disclaimer

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

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

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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.



Deprivation of Liberty Safeguards Final Internal Audit Report

January 2025

Powys Teaching Health Board



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Health Board



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Auditors:	Ian Virgil Head of Internal Audit John Cundy Principal Auditor
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Committee:	Audit Risk & Assurance Committee



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

Acknowledgement

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

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Executive Summary

Purpose

The overall objective of the audit was to review 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.

Overview:

We have issued Limited assurance on this area.

We note that following a period of difficulty for the DoLS process due to staff shortages within PTHB and PCC the situation is now improved but is not sustainable going forward. Clarity is required over the future provision of the DoLS Supervisory Body role and there are issues around capacity and delays in key stages of the DoLS application process.

The matters requiring management attention include:

- Review of the DoLS Policy;
- Ensuring appropriate on-going provision of training around the Managing Authority responsibilities;
- Contractor supplied Best Interest Assessors should have their qualifications confirmed periodically;
- Establishing a sustainable approach for the future delivery of the DoLS Supervisory Body role;
- Improvement to the process and timeliness for authorisation of DoLS applications; and
- Case tracking and Management Information could be improved with qualitative data as well as quantitative.

Report Opinion



Limited

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives	Assurance
1 Policy and procedure documentation	Reasonable
2 Training and Accreditation	Reasonable
3 Process Operation	Limited
4 Reporting	Limited

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Policy and process document	1 Design	Medium
2	Provision of Training on Managing Authority Responsibilities	2 Design	Medium
3	BIA contractor qualification	2 Design	Medium
4	Provision of DoLS Supervisory Body role	3 Design	High
5	Authorisation of DoLS Applications	3 & 4 Operation	High
6	Case tracking	4 Operation	High

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1. Introduction

- 1.1 Our audit of the Deprivation of Liberty Safeguards (DoLS) policy and procedures was undertaken in line with the 2024/25 Internal Audit Plan for Powys Teaching Health Board ('the Health Board').
- 1.2 The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.
- 1.3 In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing 2009 amendment from the Mental capacity Act (2005), with its codes of practice, policies, rules and regulations are still extant.
- 1.4 Our review looked at the current processes for DoLS applications to ensure they are managed in accordance with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures.
- 1.5 The potential risks considered for this review were as follows:
 - Policies, procedures and responsibilities relating to DoLS are not clear resulting in non-compliance with regulations.
 - DoLS applications are not logged and actioned promptly causing delays in assessments, patient's clinical needs not being met, and possible patient harm.
 - Information used for monitoring DoLS applications is not up to date, accurate or complete and action is not taken to address backlogs, causing reputational damage to the Health Board and the risk of financial penalties.

2. Detailed Audit Findings

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.

- 2.1 The Health Board's intranet contains copies of all the extant DoLS policies and documents. The Powys County Council (PCC) website also linked to publicly available documentation on DoLS and contact details for the PCC DoLS team.

-
- 2.2 The Health Board policy documents, 'SGP 042 Deprivation of Liberty Safeguards Policy and Procedure' and 'SGP 050 SOP for Deprivation of Liberty Safeguards Signatory' are clear and concise documents. They are easy to read and understand and an excellent source of information on the Health Board's DoLS process.
- 2.3 There is an issue with the policy review date having passed, but this was explained at the outset of the audit as being due to the ongoing delay and indecision around the potential implementation of the Liberty Protection Safeguards (LPS). We further noted there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen (As noted under Objective 4). **See Matter Arising 1**

Conclusion:

- 2.4 We have identified a matter arising regarding the Health Board DoLS Policy and Procedure documentation. We have provided **Reasonable Assurance** for this objective.

Objective 2: Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.

- 2.5 The DoLS policy mandates a DoLS training requirement and that staff with key roles in the process are correctly certified and that the certifications are in-date.
- 2.6 The Health Board utilise nationally available DoLS awareness courses on ESR. (Awareness is for all staff). The courses are for level one and level two. ESR management information supplied shows 83.7% of staff have completed the level one course and 90.37% have completed the level two course. Both courses remain accessible from ESR.
- 2.7 The DoLS process is commenced by a registered nurse who completes a form 1 to start the process. Level 3 training on the MCA has been offered to registered nurses. The next series of courses are at differing locations in Powys in November 2024 and targeted at registered staff working on Adult wards, Community staff e.g. District Nurses, Therapies or Complex Care Nurses.
- 2.8 The Health Board does not currently have an on-going cycle of DoLS training directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is further noted under objective 3. **See Matter Arising 2**
- 2.9 A key role in the DoLS process is the Best Interest Assessor (BIA). We noted that the Health Board has a robust process to ensure that its directly employed BIA are appropriately qualified when initially appointed and that any certifications are maintained throughout employment.
- 2.10 There is a third-party supplier of BIA personnel, Action First, contracted to provide additional BIA on a case-by-case basis as required. At the time of the audit, we were unable to confirm what processes the Health Board has in place to ensure BIA provided by Action First are appropriately qualified. **See Matter Arising 3**

Conclusion:

2.11 The DoLS and MCA training and certification requirements for the key ward staff likely to be involved in the DoLS process are well understood within the Health Board and systems are in place to deliver. There is however a need for delivery of training on the DoLS Managing Authority responsibilities. There is also an area where work should potentially be done to confirm contractor staff are also appropriately trained and qualified. We have provided **Reasonable Assurance** for this objective.

Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary

2.12 The primary operational control of the Health Board DoLS process is provided by a DoLS Administration Team. This team is employed by Powys County Council (PCC), their services are commissioned by the Health Board. The team's responsibilities are clearly defined in the SGP042 DoLS Policy. This means that the DoLS managing authority is the ward where the patient is situated; the supervising authority is PTHB with PCC DoLS providing the administration team. The Health Board remain the Supervisory Body for PTHB but do not have a post within PTHB to undertake this role. **See Matter Arising 4**

2.13 The PCC team's DoLS application receipt and control processes are well documented and are well understood and operated effectively. They maintain a case tracker spreadsheet that contains a full and comprehensive record of all key information for the managing of a DoLS case for each patient. It supports date and deadline monitoring and effectively gives PTHB a full report on every DoLS case they are administering for them, and at what stage of the process it is at. As stated above, PTHB do not have a role responsible to oversee this and ensure the required monitoring and subsequent action is achieved. In addition, the DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to normal duties and increased difficulties fulfilling this rota and maintaining timely responses are identified. **See Matter Arising 5**

2.14 We spoke to the ward sister or leading staff nurse at three hospital locations across the health board. They all confirmed they have staff who are trained to level 3 MCA and qualified to complete the form 1 when necessary. They are aware of the guidance available to them and that they can contact the safeguarding team if they need any assistance. They did note that there is sometimes a reluctance by staff to start this process, even when qualified. There was also universal concern over the time the process can take. (objective 4 includes a comment and recommendation on qualitative information on case management).

2.15 It was acknowledged at the commencement of the audit that staff changes and shortages in both the Health Board and PCC DoLS teams had a negative effect on

the process operation. Individuals left and recruitment for replacements took a long time, leaving both teams short of key personnel. There has been additional administration recruited until March 25. This is an interim measure to ensure essential DoLS Supervisory Body processes are achieved to an acceptable level. This is managed by the MCA Senior Practitioner working outside of her role with subsequent gaps identified in the delivery of PTHB Supervisory Body, and is not sustainable. PTHB has a significant gap in the delivery of PTHB Supervisory Body function and any improvements are temporary until March 2025 and a permanent solution is required as raised to PTHB executives. **See Matter Arising 4**

- 2.16 As part of their management oversight the Health Board's Safeguarding Team carried out a MCA gap analysis including DoLS. Which identified the following:
- critical omissions in documentation;
 - No resource for a rolling training programme of DoLS awareness training;
 - Non-Compliance with requirements resulting in patients deprived of their liberty without authorisation;
 - Demand exceeds capacity; and
 - No process for court protection work.
- 2.17 The analysis findings were presented to the Health Board executive team and Senior Safeguarding Group in March 2024 with three options to address the situation. This resulted in the development of an approved improvement plan and a risk register. The improvement plan is in spreadsheet format with actions, owners, timeframe, RAG status and update information present. At the time of our audit, plan delivery is ongoing with several of the objectives completed; the plan has been updated with a 2024-25 version which is now in operation. The mitigations identified are not permanent at this current stage whilst there is no PTHB Supervisory Body practitioner, additional BIA, or administration.
- 2.18 We noted the safeguarding risk on the risk register and that it has been managed and reviewed in line with the risk management policy. We also noted that the process problems occurred when key staff left from both the Health Board and PCC DoLS teams.
- 2.19 A case tracking spreadsheet is produced by the PCC admin team to facilitate progress monitoring of the Health Board DoLS cases. This has been changed to allow PTHB to now access this spreadsheet in real time since October 2024.
- 2.20 The only target dates in the DoLS guidance relate to completion within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one. The Health Board is not currently meeting these targets as 77% of urgent applications were not completed within 7 days and 68% were not completed within 14 days. For the standard applications only 50% were completed within 28 days but the numbers are small because the majority of applications are urgent. As this spreadsheet is a new development it should be developed further and refined to facilitate target date tracking on a case-by-case basis. **See Matter Arising 4.**
- 2.21 We reviewed the assessment and decision documents for a sample of cases both granted, and not granted. All decisions were correctly and appropriately signed and

recorded. The assessments looked complete and well documented in a manner that a lay person could follow and understand the rationale behind the decision. All the decisions, forms 5 and 6 were signed electronically (Docu-sign) by an appropriately authorised signatory.

Conclusion:

2.22 The current arrangements for managing the DoLS process are not sustainable going forward due to the lack of a dedicated resource to provide the DoLS Supervisory Body role. There is also a lack of management review to ensure that DoLS applications are processed in line with required timescales. We have provided **Limited Assurance** for this objective.

Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework

2.23 We have under objective 3 reviewed the tracker spreadsheet in use since April 2024 and consider that has a complete record of the data on individual DoLS cases and consider it is sufficient to meet the requirements of the objective at this time.

2.24 The PCC DoLS admin team supply numerical information on a monthly and quarterly basis to the Health Board which identifies the volumes of cases at the various stages of the process. We note that the reports seen are quantitative only, there is no qualitative information e.g % target date achievement. We further note that review of the tracker spreadsheet highlights that there is currently a considerable delay in the appointment of BIA for urgent and non-urgent DoLS applications. **See Matter Arising 4**

2.25 The Welsh Government require an annual return on the DoLS position from all Health Boards, councils, and bodies that operate a DoLS system. They specify the format, content requirements and due date.

2.26 The Health Boards last return was prepared and submitted by the PCC DoLS admin team, on time and in the correct format.

Conclusion:

2.27 Although reporting on DoLS is currently limited and quantitative we note that it is compliant with Welsh government requirements, and the opportunities for improving reporting have only recently become available. However, scrutiny of the DoLS data is required on a consistent and reliable basis to ensure the quality of the work and timely challenge of identified gaps. We have provided **Limited Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Policy and process document (Design)		Impact
<p>There is an issue with the October 2022 review date for the Health Board’s DoLS policy having passed.</p> <p>Although this was explained at the outset of the audit as initially being due to the UK Government delay and indecision with any potential implementation of the Liberty Protection Safeguards (LPS), which were effectively ‘abandoned’ in April 2023. Currently, the DoLS policy is unable to reflect updates within its policy until PTHB determine its Supervisory Body Role, following the Local Authority notice that they cannot continue their role of DoLS Co-ordination. This remains an identified gap within PTHB. The Policy should still be formally reviewed and updated where required.</p> <p>We also noted that there is nothing in the Health Board’s Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen, and also note that the WG policy does not include reporting either.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Guidance fails to keep up with legislative changes. Out of date guidance loses credibility with its users or causes time loss as they search for an up to date version.
Recommendations		Priority
1	<p>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.</p> <p>The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).</p>	Medium
Agreed Management Action		Target Date
1	Update DoLS policy.	June 2025
		Responsible Officer
		Jayne Wheeler Sexton

Matter Arising 2: Provision of Training on Managing Authority Responsibilities (Design)		Impact	
<p>The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes.</p> <p>However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is noted under matter arising 4.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inappropriate actions being undertaken by untrained staff. 	
Recommendations		Priority	
2	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.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2	A business case will need to be made for the role of DoLS co-ordinator.	March 2025	Jayne Wheeler Sexton
	A training needs analysis will be undertaken to determine required cycle of training.	July 2025	Jayne Wheeler Sexton
	Identified training put into place for the Managing Authority.	September 2025	Jayne Wheeler Sexton

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Matter Arising 3: BIA Contractor Qualification (Design)		Impact	
Action First are contracted to the Health Board to provide BIA personnel when the demand rises above a level that can be managed by the Health Board Staff. The Health Board have been unable to confirm what/if any process exists to ensure the Action First staff are fully qualified and currently certified to fulfil the role.		Potential risk of: <ul style="list-style-type: none"> Unqualified staff working on NHS patients 	
Recommendations		Priority	
3	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.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required.	Feb 2025	Jayne Wheeler Sexton

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Matter Arising 4: Provision of DoLS Supervisory Body role (Design)		Impact	
<p>The DoLS process previously failed to operate correctly when key personnel left the Health Board.</p> <p>The current interim measure has allowed additional administration for PCC to support the DoLS process using Welsh Government grant money. The MCA Senior Practitioner is also stepping outside of her role to undertake some responsibilities required in the DoLS Co-ordination responsibility.</p> <p>However, there remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Process failure due to key staff leaving. 	
Recommendations		Priority	
4	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.	High	
Agreed Management Action		Target Date	Responsible Officer
4	<p>A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors.</p> <p>Depending on outcome of business case, recruitment into positions will be required.</p>	<p>March 2025</p> <p>June 2025</p>	<p>Jayne Wheeler Sexton</p> <p>Jayne Wheeler Sexton</p>

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Matter Arising 5: Authorisation of DoLS Applications (Operation)		Impact	
<p>Delays are currently being experienced in obtaining timely sign-off of DoLS applications.</p> <p>The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to the MCA Senior Practitioners normal duties.</p> <p>The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Unqualified staff working on NHS patients 	
Recommendations		Priority	
5	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	High	
Agreed Management Action		Target Date	Responsible Officer
5	<p>A business case will need to be made for the role of DoLS co-ordinator,</p> <p>This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.</p>	<p>March 2025</p> <p>June 2025</p>	<p>Jayne Wheeler Sexton</p> <p>Jayne Wheeler sexton</p>

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Matter Arising 6: Case tracking (Operation)	Impact
<p>The DoLS applications have timescales for completion, being within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one.</p> <p>To date the Health Board has not monitored or reported whether or not the target dates have been achieved.</p> <p>The case tracking spreadsheet updated by the DoLS Admin team, is available to PTHB in real time since October 2024 and prior to this the spreadsheet was shared for the purpose of the audit from April 2024. This identifies within that time frame for the standard applications the target date was not achieved in 50% of cases. For urgent applications, 77% were not completed within the 7 day time limit and 68% were not completed within the 14-day extended.</p> <p>We were informed by the MCA Senior Practitioner that the current demand of application's are above what the Health Board can provide with the number of BIA's available and that the procurement of Action First is dependent on WG grant money being available for this.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Failure to achieve DoLS case target dates • People within PTHB are deprived of their liberty without legal authorisation for this.
Recommendations	Priority
<p>6 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.</p> <p><i>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.</i></p> <p><i>Patterson, Liz 09/01/2025 16:35:11</i></p>	<p style="text-align: center;">High</p>


Agreed Management Action	Target Date	Responsible Officer
6 The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body.	March 2025	Jayne Wheeler Sexton
A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny.	June 2025	Jayne Wheeler Sexton
Performance will be reported into PTHB Strategic Safeguarding Group.	June 2025	Jayne Wheeler Sexton

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

Date issued: January 2025

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This document has been prepared for the internal use of Powys Teaching Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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

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Audit, Risk and Assurance Committee Update

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About this document

- 1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board. We presented our most recent Audit Plan to the committee in May 2024.
- 2 We also provide additional information on:
 - other relevant examinations and studies published by the Audit General; and
 - relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

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Accounts audit update

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

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date of completion
Audit of the 2023-24 Charitable Funds Financial Statements	Executive Director of Finance, Capital & Support Services	Audit of the financial statements to inform the audit opinion.	Audit currently in progress.	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.	Opinion prior to 30 June 2025

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Performance audit update

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

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Urgent and Emergency Care	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 - Fieldwork complete and report drafting now underway.	March 2025
		We also plan to review progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Part 2 – Fieldwork underway	March 2025

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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	<p>This work will follow on from the national report on <u>tackling the planned care backlog</u>. Whilst the exact focus of this work is still to be determined, it is likely to consider:</p> <ul style="list-style-type: none"> • 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 being drafted	March 2025
Structured Assessment 2024 - Core	Director of Corporate Governance/Board Secretary	<p>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:</p> <ul style="list-style-type: none"> • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. 	Draft report in clearance	March 2025
Structured Assessment	Executive Director of Finance, Capital	This review will examine digital arrangements, with a particular focus on	Scoping	TBC

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
2024 Deep Dive - review of investment in digital systems	& Support Services	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.		
Local work 2024 – review of arrangements for managing agency staff	Executive Director of Nursing, Women & Family Health	This work will review the Health Board’s arrangements to manage agency staff use within community hospital wards. The exact scope of the work is still to be developed.	Scoping	TBC

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Other relevant publications

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

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

Title	Publication Date
<u>Financial sustainability of local government</u>	December 2024
<u>The National Fraud Initiative in Wales 2022-23</u>	October 2024

Additional information

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

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
<u>Equality Report 2023-24</u>	November 2024
<u>Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026</u>	November 2024
<u>Interim Report 2024-25</u>	October 2024

- 8 **Exhibit 5** provides information on relevant Audit Wales consultations currently underway

Exhibit 5 - information on relevant Audit Wales consultations currently underway.

Title	Publication Date
<u>Have your say on the Code of Audit Practice of the Auditor General for Wales</u>	November 2024

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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.

Agenda item: 5.5

Audit Risk and Assurance Committee		Date of Meeting: 14 January 2025
Subject:	Counter Fraud Update Report	
Approved and Presented by:	Director of Finance, Capital & Support Services / Matthew Evans Head of Counter Fraud	
Prepared by:	Head of Counter Fraud	
Other Committees and meetings considered at:	N/A	

PURPOSE:

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

RECOMMENDATION(S):

It is recommended that the Audit Risk & Assurance Committee:

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

Assurance	Discussion	Information
X	X	

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

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

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

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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Item 5.5

Counter Fraud Update Report

14th January 2025

Patterson, Liz
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1. INTRODUCTION

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

2. BACKGROUND

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

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

3. RESOURCE UTILISATION

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

Strategic Area	Resource Allocated	Resource Used
Strategic Governance	40	35
Inform and Involve	55	49
Prevent and Deter	113	70
Hold to Account	100	71
TOTAL	308	225

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. This was then discussed at Counter Fraud Steering Group and a sub-group established to explore the model further and take forward an action plan.

5. INFORM AND INVOLVE

The Counter Fraud Team have proactively sought out front line teams who have not received counter fraud training for a number of years. This approach was identified following review of the predominantly virtually delivered training instigated as part of Covid response. Face to face training appears to be preferred by some business areas which better aligns to their working practices.

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International Fraud Awareness week took place on 17-23 November. The Counter Fraud Team undertook communications to take part in the event.

6. PREVENT AND DETER

A review of the existing fraud risk assessments has been undertaken and a number of risk assessments identified as requiring review which will be completed in Quarter 4.

Intelligence has been received relating to concerns raised at other NHS Wales Organisations relating to potential diversion of weight loss medications prescribed by NHS but then resold. Early engagement with Pharmacy colleagues has established this is a known issue to them and actions have been undertaken including creation of an updated formulary detailing a list of all official weight loss drugs that are available to prescribe as well as central control of prescribing only via weight loss clinics. Data will be monitored moving forward based on the new formulary for assessment.

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.

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AUDIT, RISK & ASSURANCE COMMITTEE		DATE OF MEETING: 14 January 2025
Subject:	Post Payment Verification Mid Year Report – 1st April 2024 to 30th September 2024	
Approved and presented by:	Executive Director of Finance, Capital and Support Services	
Prepared by:	Amanda Legge - Post Payment Verification Manager	
Considered by Executive Committee on:	N/A	

PURPOSE:

This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. It also compares the overall performance of the Health Board against the national PPV visits.

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

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In 2023-2024, PPV began recovering from a new General Medical Services (GMS) payment system and a backlog of work and completed 174 GMS routine visits and 29 GMS revisits across Wales. This new financial year we have concentrated on both our revisits that were overdue and routine visits and continue to maintain an excellent level of PPV across all disciplines, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed. The following key points should be noted:

The following key points should be noted:

General Medical Services (GMS): This financial year, we have been concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

In 2024-2025, we have 16 visits due for Powys Teaching Health Board which is made up of 7 routine visits and 9 revisits and we have 5 visits finalised or in progress. As revisits check 100% of the services triggered from the original routine, they take longer to complete. We are behind with GMS across Wales, and still recovering from the pandemic and a new payment system.

General Ophthalmic Services (GOS): The visit plan for GOS 2024-2025 is a rolling plan of 3 years. PPV began remote access options last financial year having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records and we did not manage to complete all the visits that were due.

This new financial year of 2024-2025 we are on target with 9 visits planned and have 3 either finalised or in progress. We have had to also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): In 2024/2025 NWSSP/PPV introduced a new service check following a successful pilot, which was the Collaborative Working Scheme. We now verify this service along with the Quality and Safety Scheme remotely. We are also investigating other avenues for PPV in GPS and hoping to begin another pilot early this year. We have currently 8 visits to complete, with 8 visits now in progress.

Additional Services: We are progressing with our quarterly dispensing data checks and are introducing a robust service moving forward which may result in future financial recoveries once agreed by our Health Boards. These will be added to our PPV reports once finalised. From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.

Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We were planning to conduct a pilot with the Self Assessments for Pharmacies in 2024-2025 but this is currently on hold and in discussion.

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Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks.

We are also investigating other avenues for savings from the provision of Clinical Waste services and produce a 'non-collection' report to all our Health Boards.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training events continue to be delivered to our Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting.

RECOMMENDATION(S):

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for **Assurance**.

The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Approval/Ratification/Decision ¹	Discussion	Information
R	✓	R

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

Strategic Objectives:	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	
	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. Transforming in Partnership	
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	

Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	Adverse	Differential	Positive	<p align="center">Statement</p> <p align="center"><i>Please provide supporting narrative for any adverse, differential, or positive impact that may arise from a decision being taken</i></p>
Age					
Disability					
Gender reassignment					
Pregnancy and maternity					
Race					
Religion/ Belief					
Sex					
Sexual Orientation					
Marriage and civil partnership					
Welsh Language					
Risk Assessment:					
	Level of risk identified				<p align="center">Statement</p> <p align="center"><i>Please provide supporting narrative for any risks identified that may occur if a decision is taken</i></p>
	None	Low	Moderate	High	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

Patterson, Liz
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Audit Report - 1st April to 30th September 2024 = Powys Teaching Health Board

To Note	Summary of themes/findings/issues
Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers	Revisits are taking longer than expected due to 100% check of claims
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations	Revisits are normally expected to have higher claim error rates
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise	
Training/support is provided to practices after visit and throughout the year, whenever requested	

GMS	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	All Wales Visits Due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
	Routine	7	1	3	£155.05	152	35	1002	£27,655.66
Revisit	9	4	192	£6,408.92	241	54	2998	£73,022.14	
TOTAL		16	5	195	£6,563.97	393	89	4000	£100,677.80

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
PRACTICE 1	Routine	3	1.92%	£112.50
PRACTICE 2	Routine	3	1.81%	£155.05
PRACTICE 2	Revisit	37	40.22%	£4,425.75
PRACTICE 3	Revisit	152	47.50%	£1,870.67

GOS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
	Routine	9	3	5	£253.54	126	59	217	£8,987.03
Revisit	0	0	0	0	5	0	0	£0.00	
TOTAL		9	3	5	£253.54	131	59	217	£8,987.03

Summary of themes/findings/issues

As contractors are transitioning to electronic records, remote access and physical visits are progressing well

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	2	1.94%	£82.18
Practice 2	Routine	1	0.97%	£44.00
Practice 3	Routine	2	1.94%	£127.36

Summary of themes/findings/issues

Nothing to report at this stage

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
	Q&S Scheme / Collaborative Working Scheme	Routine	8	8	0	£0.00	238	112	0
TOTAL		8							



GIG
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WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 5.7

AUDIT, RISK AND ASSURANCE COMMITTEE	14 January 2025
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Subject:	SINGLE TENDER WAIVERS
Approved and presented by:	Director of Finance, Capital Estates and Support Services
Prepared by:	Assistant Director of Finance (Accounts and Services)
Other Committees and meetings considered at:	N/A

PURPOSE:
To inform the Audit Risk and Assurance Committee that there has been no Single Tender Waiver requests made between 1 October 2024 and 31 December 2024.

RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to:

- **NOTE** there has been one Single Tender Waiver requests made between 01 October 2024 and 31 December 2024.
- Take **ASSURANCE** that the organisation has an appropriate system in place to capture and report single tender waivers.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

Objective	Alignment
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:

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:

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
STW2425038	QUOTE	Welsh National Opera	Extension to Weof Wellness with WNO pilot to 31st March 2025	Continuation of work linked to previous undertaking and timescale	31/10/2024	£12,500	6 months	Prospective	A1

NWSSP Procurement use a central register 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 first 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

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



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Powys Teaching
Health Board

Agenda item:5.8

AUDIT, RISK AND ASSURANCE COMMITTEE **14 January 2025**

Subject:	Records Management Improvement Plan Update
Approved and presented by:	Helen Bushell, Director of Corporate Governance & Board Secretary
Prepared by:	Document & Records Manager Head of Information Governance, Records and Data Protection Officer
Other Committees and meetings considered at:	Executive Committee – 8 January 2025

PURPOSE:

The purpose of this paper is to address the recommendations from internal audits and provide an update on the wider records management workplan. Specifically, this paper aims to:

- Provide a position statement regarding the 2019 and November 2024 Records Management Internal Audits.
- Present a progress update of the wider records management workplan.
- Highlight key achievements and areas for improvement in records management practices.
- Provide a roadmap for future initiatives and strategies to enhance records management within the organisation.

This paper seeks to ensure transparency, accountability, and continuous improvement in our records management processes, aligning with best practices and regulatory requirements.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to:

1. **RECEIVE** 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. **RECEIVE** the update report in relation to the records management work plan taking **ASSURANCE** that a robust programme of activity is in place

3. **NOTE** 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.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	N	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:

Below is a summary for this reporting period with additional information provided in the detailed background and assessment section:

Achievements

Records Management 2019 Internal Audit 'no assurance' - all outstanding actions have now been completed.

Records Management 2024 Internal Audit – the audit has concluded, and substantial assurance provided with one priority recommendation made.

Central Records Repositories: - Work continues to move to three centralised facilities for archive health records:

- new records storage request process, managed by the Information Governance team, is operational and supported by the IGP 024 Records Storage Request Procedure and online form records storage request form.
- Security options to monitor and control access to these premises are being explored.
- Business paper being finalised with options to better manage these facilities going forward.

Records Management Policies & Procedures – A comprehensive review and update is now complete with 4 new procedures, 1 procedure review and 1 new policy completed since the last report. There is now a full suite of Records Management Policies and Procedures available for staff ensuring a robust framework is in place.

Information Asset Register –the new Information Asset Register platform was launched in September 2024 supported by the IGP 022 Information Asset Procedure and guidance document, enhancing our ability to manage information assets effectively

Information Asset Owners and Administrators – An IG & Records Management Operational working group has now been established commencing in January 2025. The purpose of this group will be to enhance data protection compliance, promote best practices and ensuring adherence to relevant legislation and regulations.

Training – Five Health Board staff completed IHRIM Certification in Records Management in 2024 and passed, with distinction. Four staff are currently enrolled to sit the examination in 2025, further demonstrating our commitment to professional development and competency in records management.

IG Bespoke Training – An online training form has been deployed for staff to request bespoke internal training from the team.

Risk Assessments – Implementation of a local Records Management Security checklist has ensured all records storage locations are identified and assessed for risks and security concerns, with known issues and risks added to local risk registers and actions monitored by the Information Governance Team.

Destruction of Records – Significant progress has been made in the destruction of records with over 25,000 records destroyed following the lifting of the embargo. Work will continue to support services to ensure compliance with current records retention guidance.

Challenges

Destruction of Records Programme - issues continue to be raised with services who are struggling to progress due to lack of administrative capacity to cope with the volume of records, or lack of knowledge and experience to appraise records, this in turn is impacting on progressing the wider workplan such as:

- Identifying storage space for re-use
- Conflicting and hindering deadlines set in other service areas
- Meeting legislative requirements
- Mitigating existing risks and health and safety issues
- Prioritisation of work against clinical/existing duties
- Not following existing processes e.g. not using intelligence tracking

Maintenance and Compliance of archive facilities – issues around the general condition with some of our storage facilities have been highlighted following a number of site inspections. Actions identified are being addressed and a further assessment addressing security and fire is due to take place during Q4.

A new Records Security Checklist has been developed to identify any existing security risks. The results of these will be considered with our Estates team to develop a plan to undertake works to ensure compliance is achieved.

Spa Road - A business case will be developed in Q4 outlining options for the management of the storage of records at Spa Road Llandrindod Wells to enable us to consider how we progress this facility.

Ongoing Improvement Areas:

- **WCCIS and replacement system** – Work continues with Digital Transformation and operational services to ensure records management considerations are adopted for any service onboarding to WCCIS and replacement system.
- **Digitisation of Records** – work continues on the Connecting Care programme and digitisation of records and reducing the amount of paper created will be considered as part of this project.

- **Records Management Strategy** – this will be incorporate into an Information Governance and Records Management Strategy, due for completion by the end of Q4 with an accompanying improvement plan which will set out the roadmap of improvements for the next three years.
- **Service Engagement** – To improve, in this area an Information Governance and Records Management working group has been established to improve service engagement and assist in compliance, promote best practices and ensuring adherence to legislation and regulations.

DETAILED BACKGROUND AND ASSESSMENT:

2019 Internal Audit - considerable progress has been made to complete the remaining actions summarised below:

Strategy, Policies, Procedures, Processes - The following have been developed and launched:

- IGP 021 Records Management Policy (New)
 - IGP 019 Corporate Records procedure (New)
 - IGP 007 Health Records Procedure (Review)
 - IGP 022 Information Asset Procedure (New)
 - IGP 024 Records Storage Request Procedure (New)
 - Information Asset Register Guidance (New)
- ✓ A new IG team activity tracker is in the final testing stages which will support the ongoing review and management of existing Policies & Procedures
 - ✓ New SAR tracker is in development which will streamline the access to records process
 - ✓ Bespoke training is available for staff on request for support knowledge and adherence.

Risk Management

- ✓ Training Needs Analysis developed, and work will commence next year to progress this
- ✓ IG/Records Management Internal Training Request form launched
- ✓ Risk Management Training Programme is in development by the Corporate Governance Assurance Team
- ✓ Records Storage Security checklists have been implemented for use in all records storage areas. All risks and issues identified will be managed in line with current risk management processes and monitored by IG for progress on actions.

Further work has also been undertaken to strengthen our position against already completed recommendations as follows:

Accountability, Leadership, and coordination of Records Management

- ✓ Continued coordination of engagement and activities across services
 - Raised the profile of the Information Asset Register
 - Launched the new Information Asset Register
 - Developed and launched IGP 022 Information Asset Procedure and a guidance document for staff
 - Undertook training sessions with services
 - Established an IG/Records Management Operational Group commencing January 2025, to provide support and guidance to IAA/IAO on all IG & Records Management issues/topics
 - Internet pages will be updated to include Caldicott Guardian details

Identification and Tracking of Records

- ✓ A new process for requesting the storage of archive records has been developed and implemented which requires all requests for the storage of records to come to IG for action and allocating. This will ensure the 3 identified archive storage locations will be fully utilised.

Security and location of Records

- ✓ Ongoing scoping exercises with services to identify volume and location of records
- ✓ Security arrangements are being reviewed in partnership with Estates and Facilities to support future archive repositories
- ✓ Records Security Checklist deployed, for completion on all records storage locations which supports compliance and identification of security risks

Storage of Records

- ✓ Online Records Storage Request Form deployed for archive storage facilities; to streamline processes and this is managed by the IG team. Records Storage Procedure has been implemented to support the new process
- ✓ Planning continues to implement three designated archive storage facilities, overseen by the IG Team

Internal Audit 2024

Internal Audit revisited Records Management in November 2024:

- Final report has been issued with assurance awarded as 'substantial'.
- One medium priority recommendation has been made relating to lack of fire suppression systems within records storage areas. A management response has been issued back to the auditor and work has commenced with the Associate Director of Capital, Estates and Property to develop an action plan to address this.
- A further update will be provided in the next update paper

NEXT STEPS:

- 1) Team continue to support any work required to meet the recommendation made in the 2024 Internal Audit
- 2) The team will persist in addressing challenging areas to ensure continuous improvement and success, and escalate areas of concern
- 3) Complete the Information Governance and Records Management Strategy and provide a 3-year improvement plan aligning to Health Board objectives
- 4) Advance the development and progression to designated records.

APPENDICES

1. 2019 Internal Audit Recommendations Progress Table (appendix 1)
2. Records Management Internal Audit (Jan 2025) – provided within overall agenda of the meeting.

Patterson, Liz
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IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
					Effective records management ensures that critical safety protocols and procedures are well-documented and easily accessible. If records are not handled safely it can lead to incidents due to missing or inaccessible information.
Safe			X		Streamlined records management processes allows for quicker and more efficient access to information. The records are properly managed and reduces time and resources searching for records. Good records management supports a person-centred approach by ensuring all relevant information about an individual is readily available.
Timely			X		
Effective			X		
Efficient			X		
Equitable					
Person Centred			X		Improved records management reduced the administrative burden on clinical and administrative staff allowing them to focus on core duties.
Workforce			X		
Leadership			X		
Culture					Have access to update to date and accurate information and robust records management processes in place enables leaders to service plan and make informed decisions.
Information			X		
Learn, Improve, Research			X		
Whole Systems Approach					Good records management ensures that information is reliable and easily retrievable, this supports transparency and accountability within the health board. Having a streamlined whole systems approach for paper records ensures that the correct systems are in place which will have a positive impact on the health board's compliance.
			x		

EQUALITY:

	No impact	Negative	Positive	Both	
					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.
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)	
					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.
Clinical	X				
Financial	x				
Corporate	X				
Operational	X				
Reputational	X				

Person: Liz
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FTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Recommendation	Management Response	Status	Work completed to meet recommendations	Progress being made to implement recommendation
1. Accountability, leadership, and coordination of records management	Records Management	No	DDIT	Head of IG, Records & DPO	The health board should strengthen its leadership arrangements and the coordination of its approach to enable effective records management. Individual roles and responsibilities should be reviewed, defined and documented accordingly, either within the most appropriate policy or a separate roles and responsibility document	Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	Complete	Document & Records Manager now appointed and in post Head of IG, Records and DPO now in post Project Manager appointed for Digitisation of Records Project All staff job descriptions have been updated to reflect responsibilities in records management. Records Management section on IG page live on the intranet as at Jan 2023 All policies and procedures are now documented with clear roles and responsibilities relating to records management. Structure in place for records management attendance at meetings such as -Property & Accommodation Group - physical storage concerns -WCCIS Management & Operational groups -HRMAM for national records-related issues -FTHB Destruction of Records Task and Finish Group -Digital Transformation & Informatics Onsite Support days Key roles and responsibilities in IG/Records Management are relayed to staff during bespoke training sessions and included in National IG Mandatory E-Learning Information Asset Register has been launched across the organisation with a procedure, guidance document and a training package deliverable upon request. RAI/IAO working group has been set up to encompass IG/Records Management discussions/topics Added information on Caldicott Guardian to internet page	
2. Strategies, Policies and Procedures	Records Management	No	DDIT	Head of IG, Records & DPO	In order to ensure correct and up to date policies and procedures are accessible to all staff, policies and procedures need to be reviewed and updated to reflect current legislation, All Wales guidance and current working practices. Once updated and approved, the policies and procedures should be communicated to staff. The health board should consider rolling out training / workshops to remind staff of the agreed procedures and practices to ensure consistent application.	Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation Publish the updated Policy and Procedures, raising awareness across the organisation Introduce a programme of records management training for clinicians and staff, including management of identified risks	Complete	A Records Management Policy & Procedure schedule has been created to identify the suite of Policies, Procedures and Guidance required to meet the internal audit recommendations and those on the wider IM workplan. GP 014 Records Management Framework GP 010 Access to Information Procedure GP 005 Destruction of Records Procedure GP 008/009 removed and archived as no longer required. GP 002 FO and EO Procedure GP 017 Records Management Code of Practice for Health & Social Care 2022 highlighted a change to retention periods for various health records. Existing documents that contained retention periods have been updated to reflect this new document. GP 018 Clinical Record Keeping Policy GP 019 Corporate Records Procedure now live GP 007 Health Records Procedure updated and now live, encompassing adoption and transfer/transition sections. GP 021 Records Management Policy now live GP 022 Information Asset Procedure now live GP 024 Records Storage Request Procedure now live Information Security Policy Development of a Records Management page on the IG intranet site that links to current policies and procedures and guidance. This is regularly updated. Redaction Guidance for staff IG staff leaflet revised to include records management. Regular tailored local training sessions are offered to services on request. The national e-learning IG mandatory module has been updated in line with legislative requirements and also now covers Records Management and Cyber Security	
3. Identification and Tracking of Records	Records Management	No	DDIT	Head of IG, Records & DPO	The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures should be developed, but aligned to the policies regarding records management and tracking. Practices should be consistent from one site to another. The health board should strengthen the current processes for the transport of health records through the introduction of standard packaging and labelling requirements along with a standard signatory system for collection and delivery. The health board should investigate the access issues to Wye Valley NHS Trust's digital records, including the extent this applies to other NHS organisations, and review the information sharing protocol to ensure a better flow of patient information. The health board should ensure robust business continuity arrangements are in place to minimise the impact of system outages, WCCIS in particular, and work with the local authority to ensure the effective implementation of the integrated system, including the merging of multiple records and removal of duplicate records to create one single record.	Review and update procedures and guidance to support effective tracking of records Ensure adequate Business Continuity Planning arrangements are in place relating to records management Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation Develop a business case for the digitisation of active records Review information sharing protocols in place for commissioned services	Complete	The business case and rollout of Intelligent Tracking is complete with guidance and training available for all staff. Regular data quality and performance reports are made available to service leads. Health Records Procedure details guidance for manual tracking of records for those not using Intelligent Tracking Confidential waste contract has been renewed and is managed by Support Services. Destruction certificates are provided and confidential waste bags are held in a secure area before collection. A recent scoping exercise identified that all hospitals have a secure location for mail to be picked up/dropped off. Local security plans developed by Facilities & Support Services Manager cover records management elements. The Information Asset Register has been promoted throughout the health board. The link to access is on the Records Management section of the intranet and regular reminders are added to the IG alert issued to staff. A scoping exercise was undertaken by an external consultancy company during March 2022 focussing on the health boards health records. A business case highlighting the outcome from this exercise, risks and next steps was developed. However progress has been stalled due to a lack of funding for the Digitisation of Records Project. A further scoping exercise has been undertaken by the IG team as part of the Destruction of Records T&F group. WCCIS performance improved since server capacity increased. Newly appointed Service Improvement Manager for WCCIS works closely with the Document & Records Manager and has developed a Service Improvement Plan to address issues with system performance and staff engagement. Local SOPs are being reviewed and developed to address issues raised such as merging duplicate records, to ensure good practice and business continuity arrangements. A business case was developed for the Digitisation of Records but progress has not been made due to a lack of available funding. An alternative solution, using an existing system such as WCP, is currently being explored. A number of national projects have been commenced (cross border, Welsh Nurse Care Records, WCCIS) to support digitisation of records Information Asset Register has been launched. This will support the Document & Records Manager to regularly audit entries and monitor areas of non-compliance Records Storage Procedure has been implemented which requires all requests for the storage of records to come to IG for action and allocating. This will ensure 3 identified archive storage locations will be fully utilised A task and finish group with leads from all services, was established to ensure a co-ordinated approach to the destruction of records across the health board. Services were asked to identify all records held, both paper and electronic, and this data has been cross referenced with data sourced from a scoping exercise undertaken by the IG team to ensure accuracy. Work is ongoing to address the issues raised. The development of the records storage security checklist and IAR will provide IG with inventory of Corporate records. Business Continuity plans are in place for WCCIS and all other digital systems	
4. Security of Records	Records Management	No	DDIT	Head of IG, Records & DPO	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained and that the points raised in this report are addressed, where weaknesses are identified.	Explore and secure suitable storage spaces (on site or off site) for the storage of active records	Complete	A scoping assessment has been undertaken by the IG team to identify the location of records throughout the health board. All records accommodation requests come through the Property & Accommodation group to ensure records are housed in suitable locations. Local security plans developed by Facilities & Support Services Manager cover records management elements. CCTV Equipment, Policy and procedures have been updated which in turn monitors the security of FTHB premises which in turn will hold records and data. Data incidents relating to physical security are reviewed by the IG Team and shared with the Facilities and Support Services Manager. Records Storage Space has been allocated within the newly acquired Welsh Government building at Spa Road in Llanidloes Wells. Work is currently underway to identify the volume of records this area will hold. IG/Records are part of the Spa Road Project Team to facilitate the move of records. An exit strategy will be developed to manage the transfer of paper records to Spa Road. Racking has now been procured and installed at Spa Road however the building is not yet secure to facilitate transfer in of records.	
5. Storage of records	Records Management	No	DDIT	Head of IG, Records & DPO	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	Explore and secure suitable storage spaces (on site or off site) for the storage of active records	Complete	Several options for on and off-site storage were considered in autumn 2020. Many on-site records stores are already breaching capacity and the Property Manager has confirmed there is no scope for releasing spaces. Further, some existing sites are not fit for purpose e.g. Bronllys creche, the garage at Ynys y Plant, Newtown. Enquiries relating to sites with potential for storage at Manhlid, Aneurin Bevan UHB, IPS in Newport and a Welsh Government Building at Newtown have been followed up, none of which have been available for FTHB use. A number of services within FTHB currently use PC archives facility at Ddole Road for offsite storage at a cost to the organisation, however use of this service is service led and there is no standard process on which records are archived. Any requests for in-house records storage go through the Property and Accommodation group for consideration to ensure that any movement of records are being allocated to suitable premises and that the archiving process has been completed correctly. The Documents and Records Manager sits on this Group An SBM was drafted and presented to the Executive Committee in March 2024 with regards to the 20 year ruling for health records, resulting in the health board now able to commence with destruction of records programme. The lifting of the culling ban has been cascaded out to services via the Destruction of Records Task & Finish Group, by email and an news item on the IG Sharepoint page A task and finish group with leads from all services, was established to ensure a co-ordinated approach to the destruction of records across the health board. Services were asked to identify all records held, both paper and electronic, and this data has been cross referenced with data sourced from a scoping exercise undertaken by the IG team to ensure accuracy. Work is ongoing to address the issues raised. Three central repositories have been identified and established for storage of archive records - Kington Undercroft, Spa Road and O Ward. Once the destruction programme reaches its conclusion, work will progress to the next phase which will involve moving the remaining active records into these three centrally managed internal storage locations. A temporary records storage area, the Body Store at Bronllys has been made available for use to ease record storage pressures as a result of health board wide office moves. As part of the Destruction of Records Task & Finish Group, services were asked to complete an audit of the location and volume of paper records held across the organisation. Completion of this from some services has been slow, and we are still awaiting the return of some. The returned audits has highlighted that some services have not been appraising records due to capacity constraints. Heads of Service have been contacted for those not engaging. Racking has now been procured and installed at Spa Road however the building is not yet secure to facilitate transfer in of records	
6. Risk Management	Records Management	No	DDIT	Head of IG, Records & DPO	Where the decision is taken to not refer an incident to the ICO, this should be documented to demonstrate that an assessment has been undertaken and to evidence the rationale for not notifying. Advice on notifications should be sought where appropriate. A review of the risks relating to records management should be undertaken. The results of this review should be reported and monitored at the appropriate health board forums on an ongoing basis. Individuals with responsibilities in relation to records management should attend the risk management training being rolled out across the health board to improve the identification, management and mitigation of risks.	Introduce a programme of records management training for clinicians and staff, including management of identified risks Ensure that risks associated with records management, including those arising from the Internal Audit review, are identified and recorded and managed in line with the Risk Management Framework Review arrangements for the reporting and management of information governance related breaches and incidents	Complete	National e-learning module has been updated to include Records Management and Cyber Security elements ABJHB offered employees of FTHB the opportunity to complete HRHM Foundation in Records Management. 6 FTHB staff are currently undertaking this course. Document & Records Manager sits on various local meetings such as WCCIS & T&F for Destruction of Records, where records related risks are discussed and identified. Information Governance team have their own risk register which sits within the Digital Transformation Directorate risk register. IG and Records related risks are identified within all service areas which are reported through the Risk and Assurance Committee regularly. These are discussed and if deemed necessary are considered for the corporate risk register. All IG (incl Records Management) incidents are reviewed, scored, and scoring is documented within the incident management system and if scoring above the threshold escalated as appropriate. GP 013 Information Governance Incident Reporting: Standard Operational Procedure has been developed to support staff Training needs analysis has been developed as part of the IG tasklist Risk Management Training Programme for FTHB staff is currently being developed by the Corporate Governance Assurance and Risk Team	

Patterson, Liz
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Audit, Risk and Assurance Committees 2024-25							
Theme	Item Title	Role of Committee	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	Approval	✓	✓	✓	✓	✓
Governance	Declaration of Interests	Compliance	✓	✓	✓	✓	✓
Governance	Action Log	Approval	✓	✓	✓	✓	✓
Governance	Annual Work Programme	Recommendation to Board	✓				
Governance	Work Programme (updated through year)	Review		✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	Review					✓
Governance	Committee Annual Report	Recommendation to Board	✓				
Governance	Audit Recommendation Tracker	Assurance	✓	✓	✓	☒	✓
Governance	WHC Tracker	Assurance			✓		✓
Governance	Register of Interests	Assurance			✓		
Governance	Register of Gifts and Hospitality	Assurance			✓		✓
Governance	Board Assurance Framework				✓		
Governance	Review of Terms of Reference	Recommendation to Board					✓
Governance	Review of Standing Orders and Standing Financial Instructions	Recommendation to Board	✓				✓
Governance	Confirmation Clinical Audit Programme in place	Assurance		✓			
Annual Accounts	Approach to the Annual Accounts	Assurance					✓
Annual Accounts	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	Recommendation to Board	✓				
Annual Accounts	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	Recommendation to Board		✓			
Internal Audit	Head of Internal Audit Opinion Draft	Assurance	✓				
Internal Audit	Head of Internal Audit Opinion Final	Recommendation to Board		✓			
Internal Audit	Internal Audit Annual Plan	Approval					✓
Internal Audit	Internal Audit Progress Report 24/25	Assurance	✓	✓	✓	✓	
Internal Audit	Internal Audit Reports (as required)	Assurance	✓	✓	✓	✓	✓
Internal Audit	Internal Audit Trend Report	Assurance				☒	✓
External Audit	Enquiries of Management and Those Charged with Governance	Assurance		✓			
External Audit	External Audit Annual Plan	Approval					✓
External Audit	External Audit Progress Report	Assurance	✓	✓	✓	✓	
External Audit	External Audit Reports (as required)	Assurance	✓	✓		✓	✓
External Audit	Structured Assessment	Recommendation to Board				✓	
Counter Fraud	Counter Fraud Annual Plan	Approval					✓
Counter Fraud	Counter Fraud Update	Assurance	✓	✓	✓	✓	
Counter Fraud	Counter Fraud Reports (as required)	Assurance	✓	✓		✓	✓
Finance and Procurement	Single Tender Waivers Annual Report	Assurance	✓				
Finance and Procurement	Single Tender Waivers (including extensions to contracts)	Assurance	✓	✓	✓	✓	✓
Finance and Procurement	Losses and Special Payments Annual Report	Assurance	✓				
Finance and Procurement	Losses and Special Payments	Assurance			✓		✓
Finance and Procurement	Post payment Verification Yr End May, Mid Yr Oct	Assurance	✓		☒	✓	
Risk	Review of Risk Management Framework	Assurance			☒	☒	✓
Risk	Assurance of Risk Management arrangements	Assurance	✓				
Hosted Bodies	Hosted Body annual report (HCRW)	Assurance		✓			
Information Governance	IG Annual Report	Assurance	D&P in May				
Information Governance	IG Performance Report	Assurance			✓	✓	✓
Information Governance	IG Toolkit (National Audit replaces Caldicott Principles)	Assurance		D&P in June			
Information Governance	Information Governance & Records Management report	Assurance	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							