Audit, Risk & Assurance Committee

Tue 15 November 2022, 10:00 - 12:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

📄 ARA_Agenda_15Nov22_v3.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 27th September 2022 for approval

📄 ARA_Item_1.2_Unconfirmed_Minutes_27Sept22_MT.pdf (6 pages)

1.4. Matters arising from previous meeting

1.5. Committee Action Log

📄 ARA_Item_1.5_Action Log_27Sept22_PH.pdf (2 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application for Single Tender Waiver

Attached   *Director of Finance and IT*

📄 ARA_Item_2.1_Application for Single Tender Waiver Nov 22.pdf (3 pages)

10:00 - 10:00
0 min

3. ITEMS FOR ASSURANCE

3.1. Internal Audit Progress Report 2022-23

Attached   *Head of Internal Audit*

📄 ARA_Item_3.1_Powys ARAC A&A Progress Report November 22 Cover.pdf (3 pages)
📄 ARA_Item_3.1a_Powys ARAC A&A Progress Report November 22.pdf (11 pages)

3.2. Internal Audit Reports: a) Control of Contractors: Follow Up (Substantial Assurance) b) Staff Rostering (Reasonable Assurance) c) Decarbonisation (Not Rated) d) Security Services (Reasonable Assurance)

Attached   *Head of Internal Audit/Executive Leads*

📄 ARA_Item_3.2a_PTHB 2223 Control of Contractors Follow Up Final Audit Report.pdf (19 pages)
📄 ARA_Item_3.2b_PTHB-2223-02-Staff Rostering-Final Internal Audit Report.pdf (14 pages)
📄 ARA_Item_3.2c_Final All Wales Decarbonisation report (PTHB).pdf (19 pages)
📄 ARA_Item_3.2d_PTHB 2223-20 Security Services Final Internal Audit Report.pdf (15 pages)

3.3. External Audit Progress Report 2022-23

Attached   *External Audit*

📄 ARA_Item_3.3_ARAC Update November 2022.pdf (10 pages)

3.4. External Audit Reports: a) National Fraud Initiative in Wales 2020-21 b) Equality Impact Assessments: more than a tick box exercise?

Attached   *External Audit*

📄 ARA_Item_3.4a_The_National_Fraud_Initiative_in_Wales_2020_21_English_0.pdf (25 pages)
📄 ARA_Item_3.4b_Equality_impact_assessment-english_0.pdf (44 pages)

3.5. Annual Governance Programme Reporting

Attached   *Interim Board Secretary*

📄 ARA_Item_3.5_Annual Governance Programme_Nov22.pdf (2 pages)
📄 ARA_Item_3.5a_Annual Governance Programme_2022-23_Q2_.pdf (12 pages)

3.6. Audit Recommendation Tracking

Attached   *Interim Board Secretary*

📄 ARA_Item_3.6_Audit Recommendations_Report_November 2022.pdf (11 pages)
📄 ARA_Item_3.6a_Appendix D - Internal Audit Recommendations that remain OUTSTANDING.pdf (5 pages)
📄 ARA_Item_3.6b_Appendix E - Internal Audit Recommendations COMPLETED since prev report.pdf (2 pages)
📄 ARA_Item_3.6c_Appendix F - Internal Audit Recommendations Not Yet Due for Imp.pdf (3 pages)
📄 ARA_Item_3.6d_Appendix G - External Audit Recs that remain OUTSTANDING.pdf (1 pages)

3.7. Welsh Health Circular Tracking

Attached   *Interim Board Secretary*

📄 ARA_Item_3.7_Welsh Health Circulars_Oct_2022.pdf (3 pages)
📄 ARA_Item_3.7a_Appendix 1_WHC's and MDs Currently Outstanding.pdf (6 pages)
📄 ARA_Item_3.7b_Appendix 2_WHCs Implemented since previous Report.pdf (2 pages)

3.8. Risk Management Framework

Attached   *Interim Board Secretary*

📄 ARA_Item_3.8_Risk Management_Nov22_final.pdf (4 pages)
📄 ARA_Item_3.8b_Appendix 2 - PTHB_Risk_Appetite_Statement_Nov22.pdf (4 pages)
📄 ARA_Item_3.8a_Appendix 1 - Revised_PTHB_Risk_Management_Framework_Nov22 (002).pdf (20 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

Attached

4.1. Community Health Council Transfer Update

Attached   *Director of Workforce and OD*

📄 ARA_Item_4.1_CHC transfer update 151122.pdf (12 pages)
📄 ARA_Item_4.1a_App 1 CHC Transfer update Oct 2022.pdf (16 pages)
📄 ARA_Item_4.1b_App 2 CHC transfer update 171022.pdf (10 pages)
📄 ARA_Item_4.1c_App 3 CHC Transfer update Oct 2022.pdf (1 pages)
📄 ARA_Item_4.1d_App 4 CHC transfer update Oct 2022.pdf (6 pages)

4.1.1.

4.2. Review of Committee Programme of Business

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Items to be brought to the attention of the Board and other Committees

5.2. Any other urgent business

5.3. Date of next meeting: 31 January 2022 at 10am

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE
COMMITTEE
TUESDAY 15th NOVEMBER 2022
10.00 – 12.00
VIA MICROSOFT TEAMS

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

	AGENDA		

Item	Title	Attached /Oral	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes from the Previous Meeting, held 27th September 2021	Attached	Chair
1.4	Matters Arising from the Previous Meeting, held 27th September 2021	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Application for Single Tender Waiver	Attached	Director of Finance and IT
3	**ITEMS FOR ASSURANCE**		
3.1	Internal Audit Progress Report 2022-23	Attached	Head of Internal Audit
3.2	Internal Audit Reports: a) Control of Contractors: Follow Up *(Substantial Assurance)* b) Staff Rostering *(Reasonable Assurance)* c) Decarbonisation *(Not Rated)* d) Security Services *(Reasonable Assurance)*	Attached	Head of Internal Audit/Executive Leads
3.3	External Audit Progress Report 2022-23	Attached	External Audit
3.4	External Audit Reports: a) National Fraud Initiative in Wales 2020-21	Attached	External Audit

	b) Equality Impact Assessments: more than a tick box exercise?			
3.5	Annual Governance Programme Reporting	Attached	Interim Board Secretary	
3.6	Audit Recommendation Tracking	Attached	Interim Board Secretary	
3.7	Welsh Health Circular Tracking	Attached	Interim Board Secretary	
3.8	Risk Management Framework	Attached	Interim Board Secretary	
4	**ITEMS FOR DISCUSSION**			
4.1	Community Health Council Transfer Update	Attached	Director of Workforce & OD	
4.2	Review of Committee Programme of Business	Attached	Interim Board Secretary	
5	**OTHER MATTERS**			
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair	
5.2	Any Other Urgent Business	Oral	Chair	
5.3	Date of the Next Meeting: • 31st January 2023 at 10.00am, Microsoft Teams			

Key:

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

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

However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact James Quance, Board Secretary, james.quance2@wales.nhs.uk).

In addition, the Board will publish a summary of meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

AUDIT, RISK & ASSURANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 27 SEPTEMBER 2022 VIA MICROSOFT TEAMS

Present:

Mark Taylor	Independent Member – Capital and Estates (Committee Chair)
Rhobert Lewis	Independent Member - General
Ian Phillips	Independent Member - ICT

In Attendance:

Carol Shillabeer	Chief Executive (Joined for part)
Pete Hopgood	Director of Finance and IT
Paula Walters	Associate Director of Corporate Business
Ian Virgil	Head of Internal Audit
Sarah Pritchard	Head of Financial services
Mererid Bowley	Director of Public Health
James Quance	Interim Board Secretary

Committee Support

Stella Parry	Interim Corporate Governance Manager
Beth Powell	Interim Corporate Governance Business Officer (covered part)

Apologies

Ronnie Alexander	Independent Member- General
Tony Thomas	Independent Member – Finance
Vivienne Harpwood	PTHB Chair

Audit, Risk & Assurance Committee
Meeting held on 27 September 2022
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Audit, Risk and Assurance Committee
15 November 2022
Agenda item 1.3

ARA/22/061	**WELCOME AND APOLOGIES**
	The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted as recorded above.
ARA/22/062	**DECLARATIONS OF INTEREST**
	The Committee Chair INVITED Members to declare any interests in relation to the items on the Committee agenda.
	None were declared.
ARA/22/063	**MINUTES OF THE MEETINGS HELD 18 JULY 2022**
	The minutes of the meetings held on 18 July 2022 were RECEIVED and AGREED as being a true and accurate record.
ARA/22/064	**MATTERS ARISING FROM PREVIOUS MEETINGS**
	The following matters arising were discussed:
	ARA/22/055: It was queried whether the Records Management Report that was discussed at a previous Delivery and Performance Committee, had been circulated to Committee members. The Director of Finance and ICT confirmed this would be disseminated to the Committee following the meeting.
ARA/22/065	**COMMITTEE ACTION LOG**
	The Committee received and NOTED the action log. The following actions were discussed by the Committee:
	• ARA/22/034, ARA/22/047, ARA/22/048: The Director of Finance and IT suggested that deadlines would be provided for each action and updated in readiness for the next meeting.

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Meeting held on 27 September 2022
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ARA/22/066	**APPLICATION OF SINGLE TENDER WAIVER**
	The Head of Financial Services presented the following application for one single tender waiver received during the period of 1 July 2022 and 31 August 2022:

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
POW2223030	Quote	Integra (E-quip) Ltd	Asset Management System for Medical Devices	Sole Supplier	13/07/2022	£5,250	1 year	Prospective	A1

The Head of Financial Services highlighted to Committee members that an administrative error of the Single Tender Waiver (STW) register log was noted for 2022/2023 in relation to STW 2223029 and therefore is the second STW for 2022-2023 and not the thirtieth.

The Committee RATIFIED the use of Single Tender Waiver in respect of 1 item during the period of 1 July 2022 and 31 August 2022.

| ARA/22/067 | **LOCAL PUBLIC HEALTH TEAM TRANSFER**
The Associate Director of Corporate Business joined the meeting and presented the item which provided an overview of the arrangements that had been implemented to transfer the local public health team function, staff and resources to the health board from Public Health Wales. Assurance was also provided in relation to the planning and implementation of the transfer and the key risks and mitigating actions that have been put in place to manage the risks and limit any adverse impact on the health board.

Committee members queried whether detailed analysis had been undertaken in relation to the implications of the grant funding utilised to fund substantive posts which were due to be transferred to the health board. It was noted that this had yet to be undertaken and the Committee suggested that an evaluation of the risk be undertaken and the findings be included to the presentation due to be made to the Board on 28th September 2022.

The Committee welcomed the update and DISCUSSED and NOTED the Report. The Associate Director of Corporate Business left the meeting. |
|---|---|

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ARA/22/068	**INTERNAL AUDIT PROGRESS REPORT 2022-23**
	The Head of Internal Audit presented the item which provided an overview of the progress against the 2022-23 Internal Audit Plan to date. It was noted that the plan for 2022/2023 was agreed by the Audit, Risk and Assurance Committee in April 2022 and is delivered as part of the arrangements established. The following matters where highlighted for the Committee's attention:
	• Two Internal Audit Reports had been finalised since the previous meeting of the Committee; one report had been rated 'Limited Assurance' and one 'Advisory'. Within the agenda, the Site Leadership and Co-ordination report has been reported as 'Limited Assurance' as an error; this should state 'Advisory'.
	• A further report that was at the draft report stage has since been reported as finalised as a 'Substantial Assurance as a follow up of a previous 'Limited Assurance' report.
	• Seven audits are work in progress with a further seven at the planning stage.
	• A detailed follow-up Audit has been added to the plan, for the previously limited assurance report on Control of Contractors.
	Committee members suggested that the scopes of audit reviews need to be made clear prior to receipt of the final reports to frame the expectations. The Head of Internal Audit confirmed that outline scopes are set in the annual plan which was agreed in March 2022 but recognised the Committee's wish to understand the detail of the scope of forthcoming reviews. Further narrative would be included within the progress report to regarding audit scopes for the November meeting.
	The Committee DISCUSSED and NOTED the update and AGREED the proposed changes to the 2022-23 Internal Audit Plan.

Audit, Risk & Assurance Committee
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15 November 2022
Agenda item 1.3

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ARA/22/069	**INTERNAL AUDIT REPORTS** *a) IT Infrastructure and Asset Management (Limited Assurance)* The Committee received the report which sought to evaluate the adequacy and monitoring of IT infrastructure within the health board. It was noted that the report had received 'Limited Assurance'. Although improvements in monitoring and updating equipment had taken place, the infrastructure still contained significant areas for improvement. The Committee DISCUSSED the findings of the report in detail and recognised the potentially sensitive nature of the report. The Committee AGREED that the report would be taken to a forthcoming meeting of the Delivery and Performance Committee for a further discussion in relation to potential impacts and prioritisation. **Action: Director of Finance and IT.** *b) Site Leadership and Coordination (Advisory)* The Committee received the report and noted that the report was an advisory review to support management rather than an assurance report. No assurance rating was therefore provided. The review suggested that the health board had developed an appropriate site coordination and leadership model which had been effectively implemented to date and was supported by robust governance arrangements. The Committee received and NOTED the Internal Audit Reports.
ARA/22/070	**EXTERNAL AUDIT PROGRESS REPORT 2022-23** External Audit presented the item which provided an update on current and planned Audit Wales work. Information was also provided on the Auditor General's wider programme of national value-for-money examinations and the work of the Good Practice Exchange (GPX). The Committee NOTED the following audits currently underway: • Orthopaedic services – follow up; • Renewal Programme; • Review of Unscheduled Care; and • Structured Assessment. The Committee DISCUSSED and NOTED the Report and welcomed the increased usage of interactive datasets.
ARA/22/071	**AUDIT RECOMMENDATION TRACKING** The Board Secretary presented the item and highlighted that in August 2022 Executive Owners were provided with an opportunity to review any outstanding recommendations from 2017/18, and 2019/20 and re-consider where appropriate, achievable final deadlines for implementation that could be monitored against. The Committee DISCUSSED and NOTED the Report, and the Chair welcomed the positive progress made against the implementation of recommendations to date.

Audit, Risk & Assurance Committee
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15 November 2022
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ARA/22/072	**ANNUAL REVIEW OF COMMITTEE TERMS OF REFERENCE 2022-2023** The Board Secretary presented the Committee's Terms of Reference for review in order to ensure that they remain fit for purpose. It was requested that any suggested amendments were relayed via the Chair or Board Secretary by 7th October 2022. The Board Secretary highlighted that it had been suggested that the frequency of meeting for 2022/24 be amended from bi-monthly, to at least quarterly. Committee Members suggested that careful consideration would need to be given to the management of committee business. The Committee Chair noted that the Terms of Reference stated that the Committee would receive a copy of the Corporate Risk Register, it was agreed that this would be discussed with the Board Secretary. The Committee NOTED the report and AGREED to return any proposed amendments by 7th October 2022.
ARA/22/073	**REVIEW OF COMMITTEE PROGRAMME OF BUSINESS** The Committee RECEIVED and NOTED the Committee programme of business.
ARA/22/074	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no matters to be brought to the attention of the Board and other Committees.
ARA/22/075	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/22/076	**DATE OF NEXT MEETING** 15 November 2022, 10:00 am, Microsoft Teams

Audit, Risk & Assurance Committee
Meeting held on 27 September 2022
Status: Unconfirmed

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Agenda item 1.3

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Key:

| Completed |
| Not yet due |
| Due |
| Overdue |

AUDIT, RISK AND ASSURANCE COMMITTEE ACTION LOG
(Following the meeting held 27 September 2022)

Minute	Date	Action	Responsible	Progress	Status
ARA/22/034	13 June 2022	A 'Register of Contracts' linked to the Single Tender Waiver process would be developed.	Director of Finance & IT	The Head of Financial Services is working in conjunction with procurement team on this action and it is anticipated an update on this will be reported to the January 2023 meeting	
ARA/22/047	18 July 2022	Work would be undertaken alongside procurement to develop an approach to ensure maintenance costs were included in original procurement costs to enable an upfront position of the cost of the contract to be provided.	Director of Finance & IT	The Head of Financial Services is working in conjunction with procurement team on this as part of the above action	

Audit, Risk and Assurance Committee
Action Log
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Audit, Risk and Assurance Committee
15 November 2022
Agenda Item 1.5

ARA/22/048	18 July 2022	The paper provided to the Executive Committee and Patient Experience, Quality and Safety Committees which provided a trend analysis of Losses and Special Payments would be shared with Members for information.	Director of Finance & IT	A paper to include a trend analysis including Welsh Risk Pool benchmarking to be included as part of the interim Losses and Special Payments report scheduled for the January 2023 meeting	
ARA/22/069	27 September 2022	The IT Infrastructure and Asset Management (Limited Assurance) would be taken forward to a meeting of the Delivery and Performance Committee for further discussion.	Director of Finance & IT	Paper to be provided to the Delivery and Performance Committee scheduled for February 2023	

Powell Bethan
09/11/2022 17:40:53

Audit, Risk and Assurance Committee
Action Log
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Audit, Risk and Assurance Committee
15 November 2022
Agenda Item 1.5

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Audit, Risk and Assurance Committee	Date of Meeting: 15th November 2022
Subject :	**SINGLE TENDER WAIVERS**
Approved and Presented by:	Director of Finance and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	None

PURPOSE:
To seek the Audit, Risk and Assurance Committee's RATIFICATION of Single Tender Waiver requests made between 1 September 2022 and 31 October 2022.

RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of 1 item during the period of 1 September 2022 and 31 October 2022 and consider additional information provided regarding the individual single tender document.

Ratification	Discussion	Information
✓		

Powell, Bethan
09/11/2022 17:40:53

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

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its September 2022 meeting which covered the period from 1 July 2022 and 31 August 2022.

A summary of the use of Single Tender Action from 1 September 2022 and 31 October 2022 is as follows:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223031	Quote	Getronics	Maintenance of Telephone System Switches	Continuation of Arrangements/Value for Money	15/09/2022	£24,600	1 year	Part - Retrospective	A1
POW2223032	TENDER	Adcuris Consulting	Demand Capacity and Financial Modelling In Support of service change from Strategic Outline Case to Outline Business Case	Continuation of work linked to previous undertaking and timescale (Links to STW POW2122018)	22/09/2022	£36,000	1 year	Prospective	A2
POW2223034	TENDER	British Pregnancy Advisory Service (BPAS)	Provision of Termination of pregnancy and Vasectomy for Powys Patients	Absence of viable NHS Supplier. Continuation of arrangement until national framework for these services is in place which is anticipated to be Autumn 2021.	26/10/2022	£153,090	12 Months	Part - Retrospective	A3

Please note due to an administrative error the STW register log for 2022/23 commenced on STW 2223029

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

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

NEXT STEPS:

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

Agenda Item: 3.1

Audit, Risk and Assurance Committee	Date of Meeting: 15 November 2022
Subject:	**Internal Audit Progress Report**
Approved and Presented by:	Board Secretary / Head of Internal Audit
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee and proposed amendments to the 2022/23 plan.

RECCOMENDATION(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.

Approval	Discussion	Information
		X

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

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

EXECUTIVE SUMMARY:

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

The following four audit reports have been finalised since the September 22 meeting of the Committee:

- Control of Contractors: Follow Up (Substantial Assurance)

- Staff Rostering (Reasonable Assurance)

- Security Services (Reasonable Assurance)

- Decarbonisation (Advisory Review)

Following a request from the Audit Committee Chair at the September 22 meeting, Appendix A of the progress report now also includes details of the outline scope for all audits that have not yet been finalised.

Powell,Bethan
09/11/2022 17:40:53

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 2022/23 plan was formally approved by the Audit, Risk and Assurance Committee at its March 22 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 proposed amendments 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.

Powell,Bethan
09/11/2022 17:40:53

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
November 2022

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit, Risk & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2022/23 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 2022/23 was agreed by the Audit, Risk & Assurance Committee in April 2022 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.
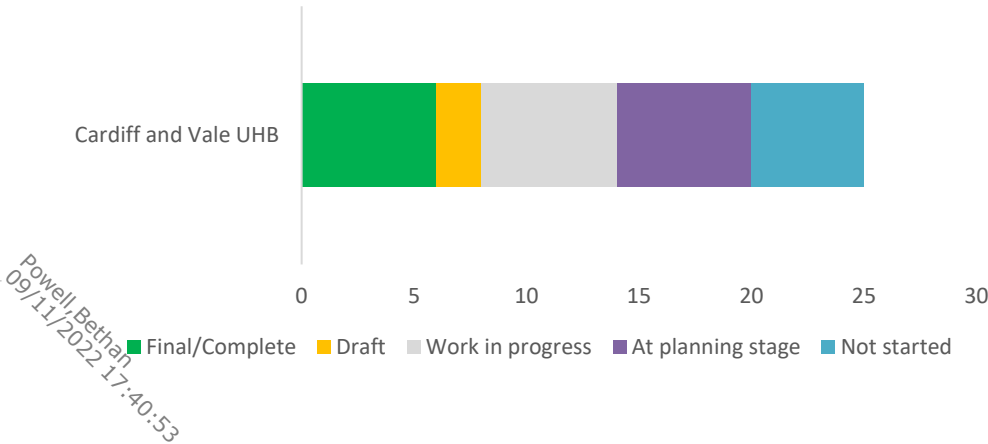
2. Outcomes from Completed Audit Reviews

Four assignments from the 2022/23 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 full versions of the reports are included in the committee's papers as separate items.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Control of Contractors: Follow-up	Substantial	
Staff Rostering	Reasonable	
Security Services		
Decarbonisation	Advisory	

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 25 reviews included within the 2022/23 Internal Audit Plan, and overall progress at this early stage of the year is summarised below.

Cardiff and Vale UHB

0   5   10   15   20   25   30

■ Final/Complete   ■ Draft   ■ Work in progress   ■ At planning stage   ■ Not started

From the illustration above it can be seen that four audits have been finalised since the Committee met last, with a further two at the draft report stage.

In addition, there are six 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 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.

4. Engagement

During the current reporting period, the Audit & Assurance team have observed Board and Sub Committees and held meetings as follows:

<u>Board / Sub Committees</u>

- Board – 28 September

<u>Health Board Meetings</u>

- Carol Shillabeer, Chief Executive – 5 October
- James Quance, Board Secretary – 20 October
- Claire Roche, Director of Nursing & Midwifery – 22 September
- Mark McIntyre, Deputy Director of Workforce and OD – 23 September
- Claire Madsen - Director of Therapies and Health Science – 14 October
- Audit Wales – 29 September
- Audit Wales & HiW – 17 October

ASSIGNMENT STATUS SCHEDULE

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Site Leadership and Coordination (Deferred from 21/22)		24	Environment	2		Final	Advisory	September
IT Infrastructure and Asset Management		9	Finance, Information & IT	1		Final	Limited	September
Control of Contractors: Follow-up		*25*	*Environment*	*1*		*Final*	*Substantial*	*November*
Decarbonisation		*22*	*Environment*	*2*		*Final*	*Advisory*	*November*
Staff Rostering		02	Workforce & OD	~~3~~	2	Final	Reasonable	November
Security Services		20	Environment	1		Final	Reasonable	November
Welsh Language Standards	Assess the processes in place to ensure compliance with the requirements of the Welsh Language Standards Act	13	Therapies & Health Science	1		Draft	Limited	January
North Powys Wellbeing Programme (Deferred from 21/22)	An assessment of the Health Board's arrangements to take the North Powys programme forward	16	Planning & Performance	~~1~~	2	Draft	Reasonable	January
Looked After Children Health Assessments (Deferred from 21/22)	Effective processes are in place to ensure that LAC health assessments are appropriately completed for all relevant looked after children	5	Nursing & Midwifery / PC&MH	2		Work in Progress		January
Charitable Funds	Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance	8	Finance, Information & IT	2		Work in Progress		January
Cancer Services - Access to Symptomatic (Deferred from 21/22)	Planned actions to allow improved access to symptomatic FIT are being effectively delivered	11	Medical / Planning & Performance	2		Work in Progress		January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Women & Children's Services Review	Review of governance arrangements, workforce management, risk management & financial management	18	PC&MH	~~1~~	2	Work in Progress		January
Workforce Futures Framework (Deferred from 21/22)	The framework has started to embed and is providing clear direction of the future work required to achieve the intended outcomes.	4	Workforce & OD	3		Work in Progress		January
Temporary Staffing Department	Review of systems and controls covering requesting, authorising & paying of bank & agency staff	3	Workforce & OD	~~1~~	3	Planning – Brief agreed with November start		January
Cyber Security	The organisation is working to improve its cyber security position, and appropriate reporting is in place that shows the current status.	10	Finance, Information & IT	~~3~~		Planning – Brief agreed with November start		January
Machynlleth Project	*Processes, procedures and operational management of the Machynlleth reconfiguration project to create a primary and community care hub.*	*21*	*Environment*	*3*		*Work in Progress*		*January*
Professional Governance Structure	Implementation of structure to provide assurance on professional oversight.	14	Therapies & Health Science	4	3	Planning		March
Performance Management & Reporting (Deferred from 21/22)	Effectiveness of the Health Board's performance management and reporting arrangements, ensuring the achievement of an Integrated approach through the Improving Performance Framework.	15	Planning & Performance	3		Planning – Brief agreed with December start		March
Planned Care / Recovery of backlog Services	Provide assurance across key areas - Community Services / planned care / recovery of backlog services	17	Planning & Performance	3		Planning		March
Covid 19 – Outbreak Control Plan, Contact Tracing	Use of WG contact tracing funding to allow health Staff to respond to Covid outbreaks.	19	Public Health	~~2~~	3	Planning		March
Savings Plans / Efficiency Framework	Development, monitoring and achievement of the Health Board's	7	Finance, Information & IT	4				March

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
	savings plans linked to recovery and the associated Efficiency Framework.							
Follow-up Action Tracker	Review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	23	Board Secretary	4				March
Board Assurance Framework / Risk Management	Focus on development of effective assurance processes alongside risk identification / escalation.	1	Board Secretary	4				April
SLAs for In-reach Medical Staff	Actions taken to review and update SLA arrangements for in-reach medical staff across all Health Board services.	12	Medical	4				April
Occupational Health Follow-up	Follow-up of 21/22 Limited Assurance report to establish progress with implementation of agreed actions.	26	Workforce & OD	4				April

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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 Rating
Site Leadership and Coordination	Advisory	Final	18/08/22	09/09/22	25/08/22	25/08/22	G
IT Infrastructure and Asset Management	Limited	Final	25/08/22	16/09/22	13/09/22	14/09/22	G
Control of Contractors: Follow Up	Substantial	Final	12/09/22	04/10/22	22/09/22	22/09/22	G
Decarbonisation	Advisory	Final	30/09/22	24/10/22	13/10/22	20/10/22	G
Staff Rostering	Reasonable	Final	11/10/22	02/11/22	20/10/22	21/10/22	G
Security Services	Reasonable	Final	25/10/22	16/11/22	09/11/22	09/11/22	G

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KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	March 2022	By 30 June	Not agreed	Draft plan	Final plan
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 8 from 8	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	100% 6 from 6	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 6 from 6	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

Office details:

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

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

Control of Contractors: Follow Up Final Internal Audit Report

September 2022

Powys Teaching Health Board

Contents

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

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 & Assurance Committee.

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

Executive Summary

Purpose

The audit sought to determine the status of agreed high and medium priority audit recommendations arising from the 2021/22 Control of Contractors audit. The report determined a limited assurance rating, with a number of significant matters identified, placing the THB at risk of potential Health & Safety Executive action in the event of adverse incidents occurring on site.

Overview of findings

Agreed actions from the prior review have been largely implemented, with 6 of the 7 recommendations now closed (including 3 high priority matters).

Only one matter remains partially outstanding, in relation to site-specific signing in protocols. Recognising the controls already implemented by the Estates team, the recommendation priority has been lowered from high to medium; with the remaining actions, due to their nature, to be undertaken in conjunction with the wider THB.

Follow-up Report Classification [1]

Substantial

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

Low impact on residual risk exposure.

Follow up: All recommendations implemented and operating as expected

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[1] The scope of this follow-up review provides assurance against the implementation of the agreed actions from prior years' audit reports. It does not provide assurance against the full scope and objectives of the original audits.

Assurance summary

	High	Medium	**Total**
Closed	3	3	**6**
Partially implemented	-	1[2]	**1**
Outstanding	-	-	**-**
Total	**3**	**4**	**7**

[2] Amended priority rating for recommendation due to scope of work undertaken by the THB to date.

Matters Remaining

		Control Design or Operation	Recommendation Priority
5.1	There is a need for tighter controls over application of contractor signing in procedures throughout the THB.	Operation	Medium

1. Introduction

1.1 The review sought to provide Powys Teaching Health Board (the THB) with assurance that appropriate and timely action has been taken in respect of agreed audit recommendations arising from the 2021/22 Control of Contractors audit (issued October 2021). The report determined a limited assurance rating, with a number of significant matters identified, placing the THB at risk of potential Health & Safety Executive action in the event of adverse incidents occurring on site.

1.2 The focus of this review was on the high and medium priority recommendations that were included within the report, with the updated position presented at **Appendix A**.

1.3 The key risk considered at this review was that the THB fails to address known concerns exposing itself to unnecessary risks.

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Appendix A: Status of previously agreed actions

Previous matter arising 2.1: Appointment of Contractors		
Original recommendation and management response		Original priority
Contractors should be periodically reminded of the THB's Health & Safety requirements, via issue of the Health & Safety Contract Rules & Guidance. **Management response:** The THB Contractor Health and Safety Guidance Booklet will be circulated to all current Estates Maintenance Contractors and a database will be created to record issue dates and frequency of issue.		**Medium**
Current findings		
THB Audit Recommendations Tracker	**Audit Observations**	**Residual risk**
Status as per Tracker: Closed	The Health & Safety Contract Rules & Guidance document was circulated to all contractors in December 2021; management have agreed the document will be reissued at a two-year frequency. **Conclusion:** Closed	N/A

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Previous matter arising 2.2: Appointment of Contractors	
Original recommendation and management response	Original priority
Contractor competencies and H&S practices should be periodically rechecked, with formal records maintained to confirm when checks were last made and are next due for review, ensuring compliance with HSE requirements. **Management response:** There is an ongoing emphasis, as noted in the audit comments, for a formal series of 3-to-5-year maintenance contract appointments to be rolled out. This involves circa 30 separate contracts with progress delayed by the Estates team focus on the pandemic response. The appointment processes are more rigorous by virtue of the tender assessments, with health and safety performance and KPIs included as part of a formal annual review arrangement.	**High**
Current findings	
THB Audit Recommendations Tracker / **Audit Observations**	**Residual risk**
Status as per Tracker: Closed	The THB is in the process of rolling out formal contracts (3–5-year periods) across all areas of estates maintenance, of which a total of 28 have been identified. At the time of the current review, 16 had been let (prioritising the highest risk areas first), with a further 12 identified which still required formal tender and contracting. The tender process includes a series of health and safety checks which addresses the original recommendation. This remains an ongoing process, monitored in conjunction with the Finance department (in respect of financial impact to budgets) and with progress reported to the Estates Compliance Group.	N/A

	The 12 maintenance areas still requiring formal contracting are being managed via rolling year-to-year orders. These areas are deemed lower risk by management, and so have not been prioritised in the above process.	
	Whilst 'appointment' checks have not been undertaken to the extent of those applied in the tender process, Estates have reiterated (as confirmed in the original audit) that insurances are re-checked on an annual basis, individual worker competencies are monitored and the long-standing nature of the relationships with these contractors provides assurance as to health and safety track record on THB sites	
	Whilst recognising that some residual risk remains until the contracting process is complete and the required health and safety checks are applied to all contractors, the progress achieved to date in the highest risk areas, coupled with the oversight processes going forward, provides sufficient assurance to close this recommendation.	
	Conclusion: Closed.	

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Previous matter arising 4.1: Management of work on site – Pre-Commencement checks (Capital)	
Original recommendation and management response	Original priority
4.1a Management should review the controls applied to the 'estates' jobs managed by the Capital Team, and ensure best practice applied in the Estates team, including use of standard processes and proformas, is applied consistently across both teams for comparable / applicable works, to ensure compliance with HSE requirements. 4.1b Job-related documentation such as RAMs, communication with contractors etc. should be filed centrally in accessible folders **Management response:** 4.1a Agreed. This audit was focussed on Estates activity, and we acknowledge that a member of our Capital team did support some emergency/urgent works in relation to roof repairs and fire doors (team member's area of expertise) but did not follow the 'Estates' processes. Further training has been given for these occasional cross-over activities and it is the case that an incident could have arisen which would not have had the full and appropriate paper trail, albeit the contractors were familiar to the Capital team member and their health and safety competency was historically good. 4.1b Job related information is retained in the maintenance file – this finding relates to the small number of jobs undertaken by the Capital team member and further training has been provided	**High**

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Current findings			Residual risk
THB Audit Recommendations Tracker		**Audit Observations**	
4.1a	**Status as per Tracker:** Closed	An electronic file structure is in place, for use by both Capital and Estates. As above, no further jobs have been managed by Capital since the audit took place. **Conclusion:** Closed.	N/A
4.1b	**Status as per Tracker:** Closed	A training session was delivered to both the Capital and Estates teams in December 2021, refreshing staff on the procedures required in the management of Estates contractors. Management confirm that no further jobs have been managed by the Capital team, since the audit took place. **Conclusion:** Closed.	

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Previous matter arising 5.1: Management of work on site – Site Access Controls	
Original recommendation and management response	Original priority
Recognising the THB's current review of local site management responsibilities (in response to the 2020/21Fire Safety audit), site access controls should be considered in tandem to ensure all contractors sign in and out, in compliance with HSE requirements. **Management response:** Agreed. The testing period was largely during COVID-19 when alternative measures were put in place which were considered pragmatic and appropriate in the circumstances. In a business-as-usual situation, with a significantly geographically spread estate and with Estates presence on only limited sites, the signing in and out process will need local involvement and buy-in. Signing-in protocols at all Reception areas has been reinstated.	**High**
Current findings	
THB Audit Recommendations Tracker	**Audit Observations**	**Residual risk**
Status as per Tracker: Closed	Following return to 'business as usual', after the lifting of Covid restrictions, visitor signing in facilities have been reinstated at individual sites. Evidence has been provided from a sample of sites that signing in books have been utilised by contractors in recent months. However, Estates advise that there may be local inconsistencies in procedures, and that contractors working outside the main building may not pass through the reception area and therefore may not sign in. It is recognised that all contractors attend either the Bronllys or Newtown Estates offices at the commencement of a job, to complete the required Contractor Job Forms and obtain visitor	Fire Safety / Security may not be adequately controlled if persons on site are not known to the local site managers.

passes. However, whilst local contact details are provided, site-specific instruction is not given at this time regarding signing-in requirements.

The Estates induction presentation states that "*contractors must sign in at the reception when arriving at work area/site location, even after signing in at Bronllys/Newtown*" and "*all operatives must sign in/out each time they leave/arrive at site throughout the day (this is for fire role call purposes and security purposes).*" This does not appear to be happening in practice in every case.

It is recognised that Estates are considering the procurement of an electronic contractor management system, which will include electronic signing in/out, and therefore mitigate this issue in the longer term. In the meantime, there is a gap in the process currently operating.

Conclusion: Partially Implemented

Recommendation		Priority
5.1a	Local site signing in requirements should be consistently applied across the THB.	**Medium**
5.1b	Induction information should be enhanced to ensure contractors are informed of local site signing in requirements prior to attending site.	

Management response	Target Date	Responsible Officer
5.1a Communications to be issued to hospital management to reinforce the importance of all Contractors following the signing-in protocols for fire safety/security reasons; signing in books for Contractors have been distributed to main Receptions at hospital sites.	October 2022	Director of Environment in liaison with site management

| 5.1b | Estates Induction Training for Contractors to emphasise message around appropriate local sign-in at sites being visited for fire safety/security purposes. | October 2022 | Head of Estates | |

Previous matter arising 5.2: Management of work on site – Site Access Controls	
Original recommendation and management response	Original priority
A written record should be maintained of the issue / return of visitor passes to contractors. **Management response:** Agreed. As per 5.1.	**Medium**
Current findings	**Residual risk**

THB Audit Recommendations Tracker	Audit Observations	
Status as per Tracker: Closed	Following return to 'business as usual', after the lifting of Covid restrictions, passes are issued to contractors from the central Estates offices in Bronllys or Newtown, prior to their attendance at the job site. Passes are sequentially numbered on printed stationery with duplicates retained in the book. **Conclusion:** Closed.	N/A

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Previous matter arising 6.1: Monitoring & reporting of contractor performance

Original recommendation and management response	Original priority
The THB should apply their existing procedures to demonstrate compliance with HSE guidance in the following areas:	
6.1a a) Apply a consistent methodology for the monitoring of contractor working practices on site as defined in the Control of Contractors policy, and through retrospective compliance auditing, i.e., a percentage of jobs to be checked, the process for documentation of checks undertaken/observations made and recording of any follow up actions completed.	
6.1b b) Introduction of a formal contractor performance review, i.e. Key Performance Indicators (KPI) to assess overall performance and assist future decision making; and	
6.1c c) Periodic reporting of the above to the relevant Executive / Committee.	
Management response:	**High**
6.1a Real time monitoring of Contractor performance in Powys is a logistical challenge. Audit and monitoring by definition, would not occur in 100% of cases. Audit identified checks being undertaken on 15% of jobs which exceeds what would be considered as industry good practice at circa 5%. We will apply the 5% rule going forward.	
6.1b The new contracts being let on 3–5-year basis have KPI monitoring and annual reviews as a core requirement in relation to performance assessment.	
6.1c Reporting of Contractor performance for Estates is reported via the Estates Compliance Group by exception with the group chaired by an Executive Director. Any matters of note or concern are escalated to the Innovative Environments Group which is chaired by CEO – any further escalations would be dictated by the group as required.	

Current findings			Residual risk
THB Audit Recommendations Tracker		**Audit Observations**	
6.1a	**Status as per Tracker:** Closed	As agreed in the response above, a 5% rate of checks was determined as reasonable by management. A central record is now maintained of all checks undertaken, confirming the current rate exceeds this target (at circa 8% for the period reviewed). **Conclusion:** Closed.	N/A
6.1b	**Status as per Tracker:** Closed	As per MA2.2, the THB is in the process of rolling out formal contracts across its key estates maintenance areas. For those contractors now under formal contract, a KPI framework has been established, with periodic meetings to formally review performance. The progress achieved to date in the highest risk areas provides sufficient assurance to close this recommendation. However, it should be recognised that some residual risk will remain until the contracting process, and enhanced performance monitoring arrangements, is complete for all contractors. **Conclusion:** Closed.	
6.1c	**Status as per Tracker:** Closed	A report was taken to the March 2022 Estates Compliance Group (ECG), setting out the new KPI process and confirming the process of escalation (including reporting to the ECG), should unsatisfactory KPI scores be determined. The ECG is chaired by the Director of Environment, with minutes shared with the Innovative Environment Group - therefore reaching an Executive	

<table>
<tr><td></td><td></td><td>audience. A review of subsequent meetings confirmed contractor performance issues had not been reported. Whilst noting this accords with the agreed procedure of reporting by exception, maintaining the subject as a standing agenda item would ensure visibility (even if a nil return is noted).

Conclusion: Closed; however, it should be ensured that contractor performance remains a standing agenda item at ECG meetings, even if a nil return is given.</td><td></td></tr>
</table>

Previous matter arising 7.1: Monitoring & Reporting – Incident Recording

Original recommendation and management response	Original priority
All contractor-related incidents / accidents should be recorded on Datix, and appropriately coded to facilitate management review / reporting. **Management response:** Very little data on Datix systems reflects the status of incidents related to Estates contractor activity, with the incident we were aware of recorded appropriately on the system. We recognise the importance of formal incident recording on Datix / Once for Wales.	**Medium**

Current findings

THB Audit Recommendations Tracker	Audit Observations	Residual risk
Status as per Tracker: Closed	Estates and Capital incidents and accidents are discussed as a standing agenda item at Health & Safety Group meetings. The importance of correct coding of incidents on Datix has been emphasised, to enable timely review by the relevant parties. **Conclusion:** Closed	N/A

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

Prioritisation of Recommendations

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

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

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

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

Website: _Audit & Assurance Services - NHS Wales Shared Services Partnership_

Staff Rostering

Final Internal Audit Report

October 2022

Powys Teaching Health Board

Contents

Review reference:	PTHB-2223-02
Report status:	Final
Fieldwork commencement:	September 2022
Fieldwork completion:	September 2022
Debrief meeting:	23rd September 2022
Draft report issued:	11th October 2022
Management response received:	20th October 2022
Final report issued:	21st October 2022
Auditors:	Andrea Calise – Principal Internal Auditor Jayne Gibbon – Audit Manager
Executive sign-off:	Deborah Wood-Lawson – Interim Executive Director of Workforce and Organisational Development
Distribution:	Mark McIntyre – Deputy Director of Workforce & Service Improvement Michelle Woods – E-Systems Implementation Officer
Committee:	Audit Risk & Assurance Committee

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

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Executive Summary

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Purpose

The overall objective of the audit was to review the controls and processes in place for the planning and management of staff rosters focusing on nursing rosters.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Sample testing revealed that a significant number of rosters are not being produced, approved, and published by wards / teams in a timely manner and in line with the Staff Rostering Policy.

- The HealthRoster system has several functionalities which are not being exploited to their full potential due to database information (rules and parameters) being out of date.

</div>

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

Objectives		Assurance
1	Staff Rostering Guidance	Substantial
2	Roster creation, approval, and distribution	Reasonable
3	Roster Efficiency	Reasonable
4	Roster Adequacy	Substantial
5	Roster Flexibility	Substantial
6	Management and oversight of Rosters	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Timely production, approval, and distribution of rosters in line with Staff Rostering policy timescales	2	Operation	Medium
2	Maximising Health Roster Functionalities	3	Operation	Medium

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1. Introduction

1.1   Our review of the 'Staff Rostering' arrangements was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board')

1.2   The Health Board's rostering arrangements are directed by the 'Rostering Policy', which was approved by the Executive Committee in December 2019 and is published on the Health Board's intranet. The Policy highlights the value of staff, and the need to provide support to staff and to provide a high-quality patient care. It also recognises that a flexible, efficient, and robust rostering system is key to achieving these objectives.

1.3   The policy has been developed to identify the core principles which must be complied with to facilitate the effective use of rostering via electronic or manual systems and to ensure consistent rostering standards are applied throughout the Health Board. The Health Board currently uses Allocate (E-rostering system) to facilitate the nurse rostering arrangements.

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

- Roster patterns to do not reflect agreed staffing establishments, resulting in increased financial cost.

- Late preparation and agreement of rosters may impact the work life balance of staff.

- Ineffective rostering arrangements may impact high quality standards of care and exposure to greater clinical risks; and

- Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increased financial burden on the Health Board.

2. Detailed Audit Findings

2.1   The basis of our review was informed by sample testing undertaken within the following areas:

- Community Nursing (Llandrindod Wells).
- Community Nursing (Llanidloes).
- Community Nursing (Ystradgynlais Community Hospital) - D010.
- Ward Nursing (LWH). (Llandrindod Wells).
- Ward Nursing Montgomeryshire County Infirmary (Newtown).
- Ward Nursing (Ystradgynlais Community Hospital).

Objective 1: Appropriate Guidance is in place which adequately covers the roles and responsibilities for staff rostering.

2.2   The Health Board's Rostering Policy, approved by the Executive Committee in December 2019 and issued in January 2020, outlines the key rostering principles and processes to be undertaken by ward management.

2.3   Our testing identified that all six areas have assigned responsibilities within the wards/district nursing teams to implement the key processes that underpin the Policy for roster management.

2.4   The Policy is due for review by January 2023. Discussions with the E-systems Implementation Officer confirmed that the Policy is currently under consultation and is expected to meet its review date.

2.5   The Nursing teams utilise the Health Board's HealthRoster e-system for managing staff rotes. Ad-hoc training on how to use the HealthRoster and additional support and guidance with the Rostering Policy is provided by the E-systems Implementation Officer.

2.6   Guidance on how to use the HealthRoster (e-roster system) can be accessed by staff via the hyperlinks on the Health Board's Workforce Information Systems homepage (intranet).

2.7   A review of the training records confirmed that all roster creators and clinical service managers selected in this review attended HealthRoster training delivered by the E-Systems Implementation Officer.

Conclusion:

2.8   Policies and procedures are in place, and formal HealthRoster training has been delivered to all roster creators and Clinical Services Managers. We have provided Substantial Assurance for this objective.

Objective 2: Rosters are produced, signed off and published in advance by the appropriate staff and in accordance with the timescales set out in the guidance. Any changes to the published roster must be approved by the nominated person.

2.9   The Rostering Policy requires all nursing staff rosters to be created, authorised, and published through the HealthRoster system.

2.10   Ward Managers are responsible for creating the rosters and submitting these to the Clinical Service Managers for approval. Once approved, the rosters are published and are available for staff to view.

2.11   The system provides full audit trail and captures the dates and names of individuals which have performed each stage of the process. The Roster Timetable sets out the key dates for which rosters must be created, approved, and published to staff relevant to the working period.

2.12   Each full roster covers a four-week period and in line with the policy, should be produced, approved, and be published to staff at least four weeks in advance.

2.13 We performed sample testing of rosters published by the six areas in the last three months (July to September 2022) and found that not all rosters had been produced, approved, and published in a timely manner. This has been an issue known to the Health Board and since July 2022, the E-Systems Implementation Officer has been working with roster creators and clinical service managers to address timeliness compliance. (Matters Arising 1)

2.14 Changes to the published rosters must be approved by the Clinical Service Manager and testing confirmed that this was the case for all areas sampled.

Conclusion:

2.15 Sample testing identified that not all rosters are being produced, approved and published in a timely manner. This is an issue already identified by the Health Board and a process has been put in place since July 2022 in an effort to improve compliance. Our testing focused on the roster process during July, August and September 2022 and the findings suggest that further work is needed to improve this area. We have provided reasonable assurance for this objective.

Objective 3: Rosters are produced in accordance with funded nurse establishment levels, ensuring the effective utilisation of existing staff and that contracted hours are met, including make up shifts.

2.16 In line with the Staff Rostering policy, all rosters reviewed as part of our sample adhered to nurse establishment levels which are clearly set within the HealthRoster system.

2.17 We reviewed the arrangements in place for arranging makeup shifts, which account for the 1.5 hours per week that are paid (salaried) but not actually worked and is either worked back as a 6-hour shift per month, or a 12 hour shift every other month.   We were able to evidence the monitoring of makeup shifts by ward management in all the six areas sampled.

2.18 Majority of rosters reviewed in our sample met the contracted hours of the nurse establishment although there were some rosters where this was not the case, and the reasons were related to staff on short term and long-term sickness and maternity leave.

2.19 The HealthRoster system has a number of features which aim to support roster creators through the roster production and approval process. The features rely on several parameters and rules which are specific to each team and must be set up within the system by the E-Systems implementation Officer. At the time of the review, it was noted that none of the roster creators were utilising these features as most of the parameters and rules were out of date. (Matter Arising 2)

2.20 The E-Systems Implementation Officer is the only member of staff within the Health Board able to provide HealthRoster system maintenance, advanced system support and training and we recognised that managing these tasks efficiently can often be a challenge. The rules and parameters within the HealthRoster system need to be set up correctly and are specific to each team's roster. Given this, the rules and parameters of the system will require regular review and update. The Roster creators and Clinical Service Managers need to engage with the E-Systems

Implementation Officer and work to ensure that the system rules and parameters are reviewed and updated regularly. (Matters Arising 2)

Conclusion:

2.21 There are arrangements in place to ensure that rosters are produced in accordance with nurse establishment levels ensuring that staff work their contracted hours. We identified that   the "auto-roster" functionality within the HealthRoster system, which can significantly streamline the roster production process is not being utilised by roster creators as the system's rules and parameters are out of date. We have provided Reasonable assurance for this objective.

Objective 4: Rosters are fit for purpose with deployment of appropriate skills mix to ensure safe, high-quality standards of care.

2.22 Rotas in the six areas sampled reflect the skills-mix of nursing staff allocated to shifts worked.

2.23 The HealthRoster system holds live data from ESR of the training records to ensure that 'skills mix' information levels are available to roster creators.

2.24 Within the Health Roster system there is clear evidence of training records and the nominated ward/team lead for each shift worked.

Conclusion:

We were able to evidence the deployment of skill mix within the rostering process for all rosters sampled. All evidence of training is clearly available on the HealthRoster system. We have provided substantial assurance for this objective.

Objective 5: There is appropriate evidence to demonstrate that rosters have been created cognisant of agreed flexible working requests.

2.25 All Staff can request flexible work arrangements, for consideration and approval by the roster creators. The Rostering Policy clearly states that individuals can only submit up to a total of four flexible working requests over a four-week period. The maximum number of requests is lower for staff that are on part-time contract and these limits are set out within the Policy.

2.26 Discussion with the E-Systems Implementation Officer and a review of the HealthRoster system confirmed that the limits of flexible working requests are applied to staff automatically by the system in line with their contracted working hours and the maximum limits set out in the Policy. A cross check test was performed for ten random staff, and this confirmed that the allocation was correctly applied for all cases.

2.27 Each request must be submitted to roster creators up to 6 weeks in advance for review and approval. Full audit trail of requests and approvals resides within the HealthRoster system. We reviewed a sample of 20 working requests across all six areas for the roster periods of the last three months and this verified that all had been requested, were processed, and approved within the timescales set out in the Rostering Policy.

Conclusion:

2.28 There is documented evidence within the health Roster system to support formal flexible working requests and their inclusion within the off-duty rotas. We have provided substantial assurance for this objective.

Objective 6: There are appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process.

2.29 The Roster Creators meet with Clinical Service Managers on a weekly basis every Monday to review the roster for the previous working week and discuss any issues with the off-duty rotas, risk, and incident reporting and if needed, will escalate any issues to Service Management as appropriate. At the meeting the previous week's rota is also validated to ensure staff worked their respective shifts at which point the rota is "locked" for editing and information for pay is passed over to payroll.

2.30 As stated in paragraph 2.18, the HealthRoster system has a suite of functionalities which, if used correctly, can provide detailed analysis information for decision making and identifying areas for improvement. These features also rely on rules and parameters which are not currently up to date. The Matter Arising 2 sets out more information on this. (Matter Arising 2)

Conclusion:

2.31 There are appropriate management arrangement systems in place for reviewing and reporting the effectiveness of the rostering process. As with objective 3, there is scope to update the rules and parameters of the HealthRoster system so that management can utilise the data analysis features of the system to better inform decision making. We have provided reasonable assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Production, approval, and distribution of rosters (Operation)	Impact
Sample testing of the rosters published by the six areas selected in the last three months (July to September 2022) identified the following: • Eight of the eighteen sampled rosters had not been produced, approved, and published in reasonable timeframes or in line with the Roster Timetable. • One roster had no audit trail of approval by the Clinical Service Manager within the Health Roster system. We note that management are aware of the above issues and as of July 2022 a new process has been put in place in order to try to improve compliance levels. Every month, the E-Systems Implementation Officer generates a report highlighting rosters that have fallen outside compliance with the roster timetable and shares the findings with ward creators and Clinical Service Managers. However, the findings from this audit confirm that further work with roster creators and Clinical Service Managers is needed to improve compliance.	Potential risk of: • Late preparation and agreement of rosters may impact the work life balance of staff.

Recommendations		Priority
1.1	Management should remind roster creators and clinical service managers that rosters must be created, approved and published in a timely manner in line with the Rostering Policy and the HealthRoster timetable.	**Medium**

Agreed Management Action	Target Date	Responsible Officer

| 1.1 | • A monthly monitor compliance report against the Rostering policy will be produced for all rosters and shared with senior managers to ensure monitoring and corrective actions are being taken in a timely manner.

• The roster timetable will be reissued to all senior managers and roster managers. | Nov 2022

Nov 2022 | **Mark McIntyre** |

Matter Arising 2: Maximising HealthRoster functionalities (Operation)	Impact
The HealthRoster system has number of features which aim to support roster creators at roster creation stage. These features streamline the process by "auto-rostering" shifts whilst ensuring that all staff have worked their contracted hours considering the flexible working requests, shift patterns, annual leave and overtime that has been approved. The features rely on several parameters and rules which are team specific and must be set up in the system by the E-Systems implementation Officer. At the time of the review, it was noted that none of roster creators were utilising these features as most of the parameters and rules were out of date and did not reflect the teams' requirements. This issue has been previously recognised by the roster creators and by the E-Systems Implementation Officer who agreed to undertake an exercise to update the parameters and rules within the system. It is anticipated that this will be a large piece of work which requires engagement by the roster creators, clinical service managers and the E-Systems Implementation Officer.	Potential risk of: • Rosters are produced in accordance with funded nurse establishment levels, ensuring the effective utilisation of existing staff and that contracted hours are met, including make up shifts.

Recommendations		Priority
2.1	Clinical Service Managers and Roster creators should liaise with the E-Systems Implementation Officer to ensure that the rules and parameters within the HealthRoster system for all areas are up to date and working effectively to ensure maximum utilisation of the benefits and features of the "auto-roster" functionality of the system.	Medium

Agreed Management Action	Target Date	Responsible Officer

2.1	All duty rules against rosters will be reissued to ward managers to review and updated on the system to reflect current roster practice.	Dec 2022	**Mark McIntyre**
	Refresh training will be offered to all ward managers.	Dec 2002	
	Roster rules will be reviewed with the ward managers twice a year to ensure they remain up to date.	Dec 2002	

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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.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

Decarbonisation

Final Report

October 2022

NWSSP Audit and Assurance Services

Contents

Report status:	Final
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Committee:	Audit Committee

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

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1. Context

1.1   The Welsh Government is party to international agreements to reduce carbon emissions and control climate change, most notably those arising from the 2016 Paris Accord.

1.2   The "NHS Wales Decarbonisation Strategic Delivery Plan" was published in March 2021, setting interim targets (from a 2018/19 base) of a 16% reduction by 2025 and a 34% reduction by 2030.

1.3   In October 2021 the Welsh Government set out its second carbon budget, Net Zero Wales, which confirmed:

> "Our ambition is for the public sector to be collectively net zero by 2030".
>
> *Welsh Government, October 2021*

1.4   NHS Wales is also required to comply with the Well-being of Future Generations (Wales) Act 2015. It requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities, and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

2. Background

2.1   In accordance with the "NHS Wales Decarbonisation Strategic Delivery Plan", Health Boards, Trusts and Special Health Authorities were required to develop their own Decarbonisation Action Plans (DAP), demonstrating how NHS Wales organisations would implement the Strategic Delivery Plan initiatives. The DAP's were submitted to Welsh Government in March 2022.

2.2   A peer review of DAP strategies was held on 12 July 2022 led by Welsh Government and attended by all NHS Wales organisations. The general conclusions across all plans were:

- the targets detailed within the plans showed low aspirations;

- there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and

- there were a small number of issues associated with their compilation/format.

2.3   Specific feedback was also provided to each organisation by Welsh Government.

2.4   Also in July 2022, Audit Wales issued their review of Public Sector Readiness for Net Zero Carbon by 2030 (fieldwork conducted between November 2021 and January 2022). The review included an assessment of NHS Wales organisations and concluded that:

> "There is clear uncertainty about whether the public sector will meet its 2030 collective ambition. Our work identifies significant, common barriers to progress that public bodies must collectively address to meet the ambition of a net zero public sector by 2030. And while public bodies are demonstrating commitment to carbon reduction, they must now significantly ramp up their activities, increase collaboration and place decarbonisation at the heart of their day-to-day operations and decisions".
>
> *Audit Wales, July 2022*

2.5 In September 2022, Health bodies will be required to make two separate submissions to Welsh Government, the first of these being quantitative (i.e., showing progress against the baseline CO_2 figures set in 2019) and the second qualitative, being a report detailing progress against the DAP.

3. Approach

3.1 Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change as outlined above. Reviews were not scheduled at Public Health Wales or Health Education and Improvement Wales for 2022/23.

3.2 Risks to be considered included:

- Regulatory/legislative risk through not achieving mandated reductions in carbon emissions;
- Reputational risk by failing to meet emission targets.
- Failing key stakeholders by not reducing carbon emissions which have a detrimental effect on health, and thereby, not meeting the requirements of the Well-being of Future Generations (Wales) Act (2015).

3.3 Having reviewed all DAPs, supporting information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.

3.4 Accordingly, the decision was taken to affirm common themes within this report, to provide an overview of the overarching position across NHS Wales. An action plan of common themes is provided at **Appendix A.**

3.5 The audit of Decarbonisation arrangements at PTHB was one of the five fully concluded reviews and accordingly a specific action plan is provided at **Appendix B**.

4. Summary Observations

4.1   While there are variations between the NHS Wales bodies, broadly each is at an early stage of implementation. The following were common themes observed across those reviewed:

Governance

- Governance arrangements at a strategic level were generally good with senior leadership demonstrated.

- Recruiting to additional operational posts has proven difficult – with the limited appointments to date coming from the existing public sector staff pool. These appointments are key to being able to implement the agreed strategies (see **Management Action 1**).

Localised strategy

- All NHS Wales organisations supplied their Decarbonisation Action Plan (DAP) by 31 March 2022 detailing their response to the NHS Wales Decarbonisation Strategic Delivery Plan and the 46 associated initiatives.

- WG provided positive feedback to each organisation on their submissions but concluded overall that there were concerns associated with their successful delivery (primarily due to the availability of financial and physical resource), together with low aspirational targets detailed within the plans.

- Few of the strategies had been costed, and none had associated funding strategies – particularly noting that ring-fenced central funding for 2021/22 was £16m with no provision made in 2022/23 (see **Management Actions 2 & 3**).

- In each instance, the decarbonisation strategies were clearly part of corporate planning and included/reflected within the respective Integrated Medium-Term Plans (IMTPs).

Monitoring & reporting

- Organisations were ISO 14001 accredited ensuring that appropriate Environment Management Systems were in place to manage their environmental performance.

- Each NHS Wales organisation's performance will be assessed against baseline data prepared by the Carbon Trust. Issues have been identified with the baseline data and the disaggregation of the data for reporting purposes. Each organisation should seek assurance on the accuracy of the baseline data (see **Management Action 4**).

- Each NHS Wales organisation should ensure that appropriate engagement is established with NWSSP Procurement Services as a significant contributor to the carbon reductions outlined within respective DAPs and formalise arrangements as appropriate (see **Management Action 5**).

- Each organisation had met its obligations for national reporting to date.

- Internal reporting to date had understandably been limited, with the level of reporting increasing after Welsh Government's review of the DAPs.

- There was therefore a need to fully roll-out the structures to support appropriate monitoring and reporting within the NHS Wales organisations reviewed (see **Management Action 6**).

- It is important that the profile of decarbonisation is increased to reflect the challenge faced, for example general Terms of Reference are reviewed to reflect decarbonisation commitments, and decarbonisation is set as a standard agenda at all appropriate Executive meetings (see **Management Action 7**).

- Potential collaboration should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource (see **Management Actions 8 & 9**).

Project delivery

- The Welsh Government Estates Funding Advisory Board (EFAB) oversaw the allocation and delivery of the £16m decarbonisation funding for 2021/22 with each NHS Wales organisation successfully securing funding.

- In each instance, adequate records were retained to support the expenditure and the achievement of the original objectives; Post Project Completion Reports were produced and submitted to WG for all funded schemes.

- No ring-fenced WG capital funding was made available for 2022/23. WG offered up to £60k of revenue funding for schemes, however several NHS Wales organisations' bids could not be supported due to them being considered capital bids (see **Management Action 10**).

- NHS Wales Organisations were also self-funding initiatives from their discretionary programme. It is important that the cost benefit of these schemes is also subject to challenge and scrutiny for inclusion within the overall data (see **Management Action 11**).

5. Conclusion

5.1   In conclusion, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. The recommendations made aim to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

5.2   It is recommended that an audit is scheduled for early 2023/24 with the proposed scope to include governance, strategy progress and implementation.

5.3   Additionally, as part of 2023/24 Internal Audit planning update, discussions will be held with management on the appropriateness of other areas within the decarbonisation programme including, for example:

- Procurement and supply chains.
- Application of "Best practice Pharmaceutical waste practice".
- Transport.
- Fleet and business travel.
- Staff, patient and visitor travel.
- Catering; and
- People and workforce e.g., training, policies, and working arrangements.

Appendix A: Common Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
MA 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	NOTED. Roles which have a link to the increasingly prominent Environmental agenda are presenting a recruitment and retention challenge in a competitive job market and likely to only become more challenging	N/A
MA 2	DAPs should be fully costed to fully determine the total funding required.	NOTED. This has not been asked for by Welsh Government to date. A small number of Health Boards have made an attempt at this, but this was undertaken on their behalf by external	N/A

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
		companies at a cost in excess of £50k. This approach should be discussed nationally by WG and a standard approach to funding and calculating the costs should be agreed.	
MA 3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	NOTED. The national response to action MA2 should be concluded firstly. The potential to identify actions which have no cost or where costs are known can be applied to future plans.	N/A
MA 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	NOTED. The Health Board has flagged up concerns around baselines and calculations of carbon	N/A

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
		to Welsh Government and will welcome this action.	
MA 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	NOTED. Local engagement between PTHB and nominated SSP rep is in place and productive. Procurement impact is a major issue, and the national pace needs to increase.	N/A
MA 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	NOTED. See response to Recommendation PTHB 2	N/A
MA 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	NOTED. See response to Recommendation PTHB 1	N/A

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
MA 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	NOTED. The HB officers work closely with other HBs where possible and the Director attends a number of key national groups to support national agenda.	N/A
MA 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	NOTED. PTHB has worked with HEIW on the PTHB proposal for advancing Carbon Literacy training. PTHB would welcome any opportunities to work with HEIW and any other NHS Wales organisation on any training and education on the carbon/climate agenda.	N/A

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
MA10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	NOTED. Any bids by HB for national funding are considered and approved by the Director.	N/A
MA11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	NOTED. Any approach to funding within the HB would follow normal governance processes.	N/A

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Appendix B: PTHB Specific Management Action Plan

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
PTHB 1	PTHB should look to formalise Decarbonisation oversight arrangements within the Terms of Reference of existing committee/ meetings.	AGREED. The Environment Sustainability Group (chaired by the Director of Environment) provides escalate/exception reports to the Innovative Environments Group (chaired by CEO) and then on to the Delivery and Performance Committee. When terms of Reference are reviewed at normal intervals the need to be more specific about reporting detail will be considered.	Director of Environment (with Board Secretary as necessary) Deadline will be over a 12-month cycle of review of terms of references. OCTOBER 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
PTHB 2	The governance arrangements surrounding the respective work groups assigned specific initiatives and corresponding actions should be aligned to those set out in the paper presented at the Innovative Environment Group, with enhanced accountability for delivering plans formally set out.	AGREE. This action will be considered when a new version of the Decarbonisation Plan is developed. The current plan does have actions through to 2030 however there is a current expectation that a revised plan will be submitted as part of the IMTP planning cycle for 2024/25 onward. It is however necessary to not focus all actions on decarbonisation and climate impact on a single plan if we are to embed the issue in all departmental plans	Director of Environment DECEMBER 2023

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
PTHB 3	There is an established governance framework for reporting, on an exception basis, to Board and executive management. However, there would be a benefit of this becoming part of standard business and a standing agenda item.	AGREED. The move to a more detailed level of reporting which is not exception reporting only will need to be discussed as part of the wider performance framework. In line with the response to PTHB 1 – reporting mechanisms and route to Board level committee is in place. Standard reporting to WG on qualitative measures is in place on a 6 monthly cycle. Quantitative measures are in place on an annual basis (with latest return in September 2022). These are reported to	COMPLETED

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
		Innovative Environments Group The Director of Environment provides a portfolio wide report to Delivery and Performance Committee on a regular basis which will include carbon/climate matters. Latest report was in September 2022 and next will be in the meeting of February 2023.	
PTHB 4	Management should adapt and update the existing risk management tool to bring together the various risks associated with the implementation of the decarbonisation agenda.	AGREED There is a need to be consistently clear about risks to delivery and any need for mitigation or adjusted timelines. The detail of the exception	Head of Technical Services DECEMBER 2022

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
		reporting and necessary mitigating steps will be increased for future Environment Sustainability Groups It is necessary to note however that a specific risk register for decarbonisation will not be created and risks should be included in any departmental risk registers	
PTHB 5	Management should consider incorporating elements of plans of other NHS Wales organisations when revising the DAP - which we understand have been shared for this very purpose.	AGREED. PTHB officers have already participated in a national event facilitated by WG to review other organisation plans and inform future PTHB plans. As noted in response to PTHB 2,	Completed

Ref.	Recommendation	Management Comment/ Agreed Action	Management Assigned Responsible Officer/ Deadline
		there is no formal requirement to revise current plans until IMTP for 2024/25.	

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

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

Security Services

Final Internal Audit Report

November 2022

Powys Teaching Health Board

Contents

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Executive sign-off:	Jamie Marchant, Director of Environment
Distribution:	Andrew Cresswell, Assistant Director Support Services John Morgan, Support Services Manager / Security Advisor
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 Institute of Internal Auditors

Executive Summary

Purpose

The overall objective of the review was to assess the structure and effectiveness of Security Services within the Health Board.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Only three out of six operational officers sampled were fully familiar with the security policy.
- Testing undertaken for a sample of service areas found that the majority had no documented security plans in place.
- Where documented security plans are in place they are not reviewed centrally.
- Attendance and contributions at the Security Oversight Group by operational areas was poor.
- Security updates are not fed into the Health and Safety Group and onto the Executive Committee.
- Enhancements are required on the Action Log for the Security Advisory Group.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Approved and up to date Security Policy is in place which covers all key aspects of security.	Reasonable
2	Effective plans are in place to ensure the policy is appropriately deployed and implemented.	Limited
3	Appropriate governance arrangements are in place to provide effective oversight of security.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Security Policy Awareness	1	Operation	Medium
2	Existence of Security Plans.	2	Operation	High
3	Review of security plans	2	Design	Medium
4	Attendance at Security Oversight Group.	3	Operation	Medium
5	Updates from the Security Oversight Group.	3	Operation	Medium
6	Security Oversight Group Action Log.	3	Operation	Medium

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1. Introduction

1.1   Our audit review of Security Services was completed in line with the 2022/23 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2   There are many different threats to security across the Health Board, which can include risks to personal security, risks to assets and property, theft, violence, and aggression.

1.3   Through a process of assessment of security risks, plans are developed by Departmental Managers across the Health Board to implement control measures which seek to minimise the risks and so maintain a safe and secure environment for all patients and staff.

1.4   The Health Board does not have a separate specialised team who work solely on Security Services. The security work is combined with other responsibilities.

1.5   The Director of Environment was the lead for this review.

1.6   The associated risks were:

- Harm to patients and staff from security incidents.

- Financial loss arising from security incidents.

- Reputational damage to the Health Board from security incidents.

2. Detailed Audit Findings

Objective 1: An appropriately approved Security Policy is in place which covers all key aspects of Health Board security and is kept up to date.

2.1   A Security Protective Measures Policy is in place (PTHB / FTP 005) which is detailed and comprehensive.

2.2   It includes coverage of the following areas:

- Physical, cyber, and personal security.

- Executive, staff, and management responsibilities.

- Planning and recording.

- Managing risk and threat, threat level and protective measures plans.

- Monitoring compliance, audit, and review.

2.3   The policy was issued in October 2021 following consultation with the Security Oversight Group, Health & Safety Group and Executive Team and is scheduled for review in September 2023. The policy is accessible to all staff via the Facilities & Transport Policies page on the Health Board's Intranet.

2.4   From discussions that took place with a sample of six Departmental Managers it was noted that not all were familiar with or aware of the current version of the Health Board's Security Policy. (Matter arising 1)

Conclusion:

2.5   A Security Protective Measures Policy is in place which is detailed, comprehensive and up to date. However, it was noted that there was a lack awareness of the current Security Policy. We have provided Reasonable Assurance for this objective.

Objective 2: Effective plans are in place to ensure that the policy is appropriately deployed and is being implemented by staff across the Health Board.

2.6   As part of our fieldwork, we selected a sample of six Departmental Managers in order to assess their implementation of the policy and assess the security plans in place for their respective areas. Of the six Managers it was noted that only one Manager had documented security plans in place, although they had not been updated or reviewed since 2017. (Matter Arising 2)

2.7   From the discussions and information provided by the Departmental Managers we did note that there were a number of relevant policies and risk assessments in place for their respective areas that were related to security concerns/issues. However, none of the information provided could be described as effective in providing an overarching response which adequately addresses all security matters and which evidences that the policy is being appropriately deployed and implemented by staff across the Health Board. (Matter Arising 2)

2.8   With regards to the existence of local security plans we note that currently there is no suggested template for a plan, linked to the current Security Policy, which could explain the absence of documented plans for those areas selected in our sample. (Matter Arising 2).

2.9   If there are Security plans in place they are not currently held or reviewed centrally, as primary responsibility lies with the operational owners. As identified in paragraph 2.6, whilst one service area had plans in place they were out of date. Consideration should be given to reviewing all plans at least annually at an appropriate forum such as the Security Oversight Group. (Matter arising 3)

2.10 Discussion with the various operational officials suggests that staff are generally aware of security matters and that appropriate action such as escalating an issue within the local operational structure or reaching out to specialist support services would be taken.

Conclusion:

2.11 The quality of the responses to our requests for security plans was variable and whilst additional information was provided none could be described as effective in providing an overarching response which adequately addresses all security matters and which evidences that the policy is being appropriately deployed and

implemented by staff across the Health Board. We have provided Limited Assurance for this objective.

Objective 3: Appropriate governance arrangements are in place to provide effective oversight of security arrangements.

2.12 A Security Oversight Group is in place which meets quarterly and for which agendas, papers, minutes, and terms of reference are in place.

2.13 A wide range of security matters are covered by the group including general security matters, security incidents which have occurred, CCTV Contracts and Installations, Cyber Security, Civil Contingency and Local Resilience.

2.14 Attendance at the Security Oversight Group meetings by a core group of security support staff is very good with all or most meetings in the last year having been attended. However, contributions to the meetings are predominantly from these staff and attendance from operational areas is very poor. (Matter arising 4)

2.15 The Security Oversight Group's Terms of Reference states that it feeds into and is answerable to the Health and Safety Group which then feeds into the Executive Committee. However, updates have not been provided to the Health and Safety Group in the last year and standing items are not included in either the Security Oversight Group or Health and Safety Group agendas to ensure that this occurs. (Matter arising 5)

2.16 A review of the minutes and action logs of meetings of the Security Advisory Group found them to be very comprehensive. We did however note that updates on progress on some of the actions are not always completed with a verbal update being provided at the meeting instead. It was also noted that there are two actions regarding management of locks and keys and CCTV contracts where little progress has been made since being added to the action log in 2021. (Matter arising 6).

2.17 The Support Services Manager / Security Advisor undertakes advisory security audits when requested by operational departments and relevant training has also been developed and provided.

Conclusion:

2.18 Our review of the governance arrangements found that whilst appropriate structures and groups are in place, improvements are required in a number of areas such as attendance, record keeping and updates to the Health & Safety Group. We have provided Reasonable Assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Security Policy Awareness (Operation)	Impact
As part of our fieldwork, we selected a sample of six Departmental Managers to understand their awareness of their roles and responsibilities regarding the Security policy for their respective areas of responsibility. From the discussions that took place we noted the following: • Three Managers were familiar with the current security policy; • One Manager uses an older version of the policy; • One Manager was only partly familiar with the policy; and • One Manager was not familiar with the policy.	Potential risk the security policy may not be properly and consistently implemented across the Health Board.

Recommendations		Priority
1.1	Management should provide a refresher training session for all Departmental Managers regarding the Security Policy.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	a. The PTHB Security Protective Measures Policy (FTP005) has been reinstated on the PTHB Intranet and Sharepoint Site for reference. b. This action will be discussed further during the next Security Oversight Group Meeting in December with the meeting invitation distribution List extended and updated to include a wider representation from all Departments across PTHB. c. A 30 minute slot has been reserved on the agenda for the next Site Coordinators Meeting and Health & Safety Groups in January 2023, to discuss	February 2023	Assistant Director Support Services

	the Security Protective Measures Policy and to deliver the toolbox talk on the preparation of Departmental Security Plans.		
	d. An internal communication will be made to all Departmental Managers advising them of the latest version of the Security Protective Managers Policy and its location on Sharepoint.		

Matter Arising 2: Existence of Security Plans (Operation)	Impact
One of the requirements of the Health Board's Security Policy is that each Service is required to have Local Security Protective Measures Plans in place. From our sample of six Departmental Managers selected, only one had documented security plans in place, although these were dated 2017. For the remaining five Managers, whilst we acknowledge that there are local policies and risk assessments in place regarding security issues for their respective areas there is no overarching document (plan) in place. From our review of the Security Policy, we note that whilst the policy requires each service area to have Security Protective Measures plans in place there is no suggested template for these.	Potential risk effective plans are not in place to ensure that the policy is appropriately deployed and is being implemented by staff across the Health Board.

Recommendations		Priority
2.1	Management should remind all Departmental Managers of the requirement for having Security Protective Measures plans in place for their areas of responsibility.	**High**
2.2	Management should consider developing a template for the Security Protective Measures Plans for Security Leads to complete. This will allow for consistency in the information being recorded.	

Agreed Management Action		Target Date	Responsible Officer
2.1	a. An internal communication will be made to all Departmental Managers advising them of the latest version of the Security Protective Managers Policy and its location on Sharepoint. b. This action will be discussed further during the next Security Oversight Group Meeting in December with the meeting invitation distribution List extended and updated to include a wider representation from all Departments across PTHB. c. A 30 minute slot has been reserved on the agenda for the next Site Coordinators Meeting and Health and Safety Groups in January 2023, to discuss the Security Protective Measures Policy and to deliver the toolbox talk on the preparation of Departmental Security Plans.	February 2023	Assistant Director Support Services
2.2	To date, Departments have been encouraged to use the standard risk assessment template to develop Security plans as it provides a template to assess existing risks with a revised risk following risk mitigation and consideration. A dedicated template document will be developed to record Security plans and this will be presented to the December 2022 Security Oversight Group Meeting for consideration and approval, along with potential for approval at the Health and Safety Group if necessary	February 2023	Assistant Director Support Services

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Matter Arising 3: Review of Security Plans (Design)	Impact
Where there are Security Plans in place primary responsibility lies with the department/service for their review and update. We note that no copies of the individual security plans are held centrally in order to provide assurance that they are being reviewed.	Potential risk effective plans are not in place to ensure that the policy is appropriately deployed and is being implemented by staff across the Health Board.

Recommendations		Priority
3.1	Management should consider reviewing all Security Plans at least annually at an appropriate forum such as the Security Oversight Group.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	a. Security plans will be reviewed annually through the governance structure which will consist of the Security Oversight Group, The Health and Safety Group and the Site Coordination Forum. b. Security plans will be completed and filed centrally using Sharepoint, to ensure that Departments are referencing up to date policy documentation and forms.	December 2023	Assistant Director Support Services

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Matter Arising 4: Attendance at Security Oversight Group meetings (Operation)	Impact
Attendance at the Security Oversight Group meetings by a core group of security support staff is very good with all or most meetings in the last year having been attended. However, contributions to the meetings are predominantly from these staff and attendance from operational areas is very poor with the worst examples being Community Services, having attended only one meeting and Health and Safety and Therapies and Health Sciences, having attended none at all.	Potential risk the benefit and effectiveness of the Security Oversight Group is impeded.

Recommendations		Priority
4.1	Management should issue a reminder to the membership of the Security Oversight Group (as per the Terms of Reference) of their responsibility to attend all meetings. If they are unable to attend, then a representative of their department should attend instead.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	a. We will review the Terms of Reference and membership for the Security Oversight Group during the December 2022 meeting, after which we will ask the Health and Safety Group to approve	February 2023	Assistant Director Support Services

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Matter Arising 5: Oversight of the Security Oversight Group (Operation)	Impact
The Security Oversight Group's Terms of Reference states that it reports into and is answerable to the Health and Safety Group which then reports into the Executive Committee. However, updates have not been provided to the Health and Safety Group in the last year and standing items are not included in either the Security Oversight Group or Health and Safety Group agendas to ensure that this occurs.	Lack of oversight of the Security Oversight Group.

Recommendations		Priority
5.1	Management should ensure that updates of each meeting of the Security Oversight Group are submitted to the Health and Safety Group. Management should also consider adding the updates to the respective meeting's agendas to ensure that this occurs.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5.1	a. Previously any Security Oversight Group Meeting escalation points would be taken to the Health and Safety Group Meeting by Assistant Director Support Services and Chair of the Security Oversight Group. b. Going forward the agenda of the Health and Safety Group will be amended to include an update from the Security Oversight Group Meeting.	November 2022	Completed

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Matter Arising 6: Security Oversight Group Action Plan (Operation)	Impact
When reviewing the meeting records of the Security Oversight Group it was noted that whilst the action log was presented and considered at the meetings, progress updates were not always recorded for some of the actions agreed at previous meetings. The following was also noted on 2 of the actions recorded on the action log: • An item relating to review of the management of locks and keys across the Health Board (SG/20/24) was initially raised in March 2021. This is a large project for which progress to date has been limited; and • The action relating to the review of CCTV arrangements was raised in June 2021, and as per the above point progress has been limited. (We do acknowledge that a significant part of the Group's work has been concerned with CCTV arrangements).	Potential risk of inadequate control over access to Health Board premises.

Recommendations		Priority
6.1	Prior to each meeting of the Security Oversight Group management should ensure that progress updates for all actions listed are provided and noted on the action log ahead of the issue of the meeting papers. With regards to the two actions highlighted, management should ensure that progress is kept under close review so that the actions are resolved as soon as possible.	Medium

Agreed Management Action		Target Date	Responsible Officer
6.1	a. Additional administration support is now provided to ensure that actionable items are completed and signed-off appropriately.	November 22	Completed
	b. The specific action point referred to in the recommendation is being followed up within the Directorate of Environment (which relates to key cutting procedure). The second action relates to CCTV procedure and an SBAR will be prepared for consideration by the Director of Environment.	December 22	Support Services Manager (Security Lead for PTHB)

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.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

![Archwilio Cymru / Audit Wales logo]

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

Date issued: November 2022

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Audit, Risk & Assurance Committee Update

About this document

1   This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2   **Exhibit 1** summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2021-22 Charitable Funds Account	Following discussions with management, audit work is due to start in early December 2022, with a view to submitting audited accounts before the 31 January 2023 statutory deadline.
Audit of the 2022-23 Accountability Report and Financial Statements	Audit planning due to start in early 2023 – exact timetable to be discussed with management in due course.

Performance audit update

3   The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work presented to the Audit Committee (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

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Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment (Phase 2) – Corporate Governance and Financial Management Arrangements	January 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Medical Director	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	All-Wales summary report and a discrete Annex for each Health Board being drafted January 2023
Renewal Programme Executive Lead – Director of Planning & Performance	This local work will examine the arrangements put in place to deliver the Health Board's renewal programme.	Report in clearance with the Health Board January 2023

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Fieldwork underway TBC
Structured Assessment Executive Lead - Interim Board Secretary	This work will continue to form the basis of the work we do to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. The 2022 work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).	Report being drafted January 2023
Primary Care Services - Follow-up Review	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for	Scoping March 2023

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Director of Primary Care, Community & Mental Health Services	primary care as set out in the national plan. We made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Workforce Planning	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Review currently being scoped

TBC |

Good Practice events and products

4   In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5   Details of future events are available on the GPX website. Events include sharing a range of perspectives on the impact the pandemic has had on public services in Wales two years on from the start of the pandemic. The most recent events were held during October 2022, focussing on Tackling Poverty in Wales, and there are resources available.

NHS-related national studies and related products

6   The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

7   **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Cyber Resilience Follow Up **Report received in Private Session**	October 2022
National Fraud Initiative 2020-21 **Please see Appendix 1**	October 2022
Equality Impact Assessment: More than a tick box exercise? **Please see Appendix 1**	September 2022

Appendix 1

Key messages from recent national publications

National Fraud initiative 2020-21

8   The cumulative outcomes from the National Fraud Initiative (NFI) in Wales since 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes are now £2.37 billion.

9   The NFI is a counter-fraud exercise across the UK public sector, which aims to prevent and detect fraud.

10   An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

11   Whilst the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by Welsh local authorities.

12   Our report makes several recommendations for participants in the NFI exercise including maximising the benefits of participation, acting on the results and also asking audit committees to review the NFI self-appraisal checklist.

Equality Impact Assessments: More than a tick box exercise?

13   Our work looked at the overall approach to undertaking Equality Impact Assessments in public bodies in Wales. We concentrated on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015.

14   We focussed primarily on understanding public bodies' approaches with a view to finding good or interesting practice and identifying any common areas for improvement. We did not evaluate individual public bodies' approaches in detail.

15   Our findings highlight examples of good practice in aspects of the Equality Impact Assessment process across the public bodies we looked at. However, there are areas for improvement around the following themes:

- Greater clarity over which type of policies must be impact assessed.
- Greater clarity about the arrangements for assessing the impact of collaborative policies and practices.
- Greater clarity about expectations to consider the Public Sector Equality Duty as part of an integrated impact assessment.
- Better monitoring of the actual impacts of policies and practices on people.

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Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

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The National Fraud Initiative in Wales 2020-21

Report of the Auditor General for Wales

This is an interactive pdf

To navigate through the document please use the buttons on the left side of the page and the links marked with underlined text

Key messages

Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

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Key messages

Outcomes

Results

Process

Recommendations

◄ **All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.**

◄ **Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.**

◄ **Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.**

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Outcomes

Key messages

Outcomes

NFI outcomes

NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. NFI uses data sharing and matching to help confirm that services are provided to the correct people.

An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

The NFI recorded outcomes of £6.5 million in 2020-21.

Results

£ NFI outcomes cumulatively in the UK since 1996-97

£2.37 billion

£ NFI outcomes cumulatively in Wales since 1996-97

£49.4 million

£ NFI outcomes across the UK from the 2020-21 exercise

£443 million

£ NFI outcomes in Wales from the 2020-21 exercise

£6.5 million

Process

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Key messages

Outcomes

Results

Process

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Trends in outcomes

Outcomes in Wales have decreased by £1.5 million to £6.5 million in the 2020-21 exercise. Reasons for the decrease in outcomes include:

- the number of fraudulent or erroneous claims for Council Tax Single Persons Discount detected fell from 3,939 in the 2018-19 exercise to 1,987 in the 2020-21 exercise, resulting in outcomes in this area reducing by £2 million; and

- the number of fraudulent or erroneous claims for Housing Benefit detected fell from 179 in the 2018-19 exercise to 82 cases in the 2020-21 exercise, resulting in outcomes in this area reducing by £0.6 million.

The above fall in outcomes was offset in part by:

- an increase in the number of fraudulent or erroneous applications for social housing detected from 74 in the 2018-19 exercise to 237 in the 2020-21 exercise, resulting in increased outcomes of £0.6 million; and

- the detection of 43 fraudulent or erroneous claims for COVID-19 business support grants resulting in cumulative outcomes of £0.6 million.

Outcomes of £6.5 million were identified in the 2020-21 exercise
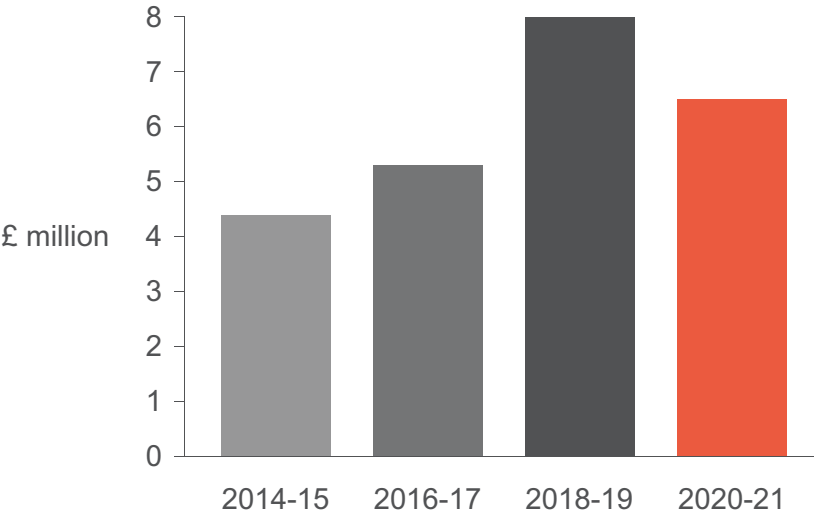
While overall outcomes have fallen, this is in part because many NFI participants started review of NFI matches later than normal due to work pressures arising from the COVID-19 pandemic.

The only UK nation which saw an increase in 2020-21 NFI outcomes was England. This increase was due to a significant increase in pension outcomes from matching UK-wide pension scheme data.

Late savings arising from NFI 2020-21 will be reported as part of the NFI 2022-23 exercise.

Key messages

How the latest outcomes compare to the last exercise

Outcomes

Results

Process

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Legend: 2018-19, 2020-21

£ million

Categories: Council tax discounts, Blue badges, Housing waiting lists, Housing benefit, COVID-19 business support grants, Council tax reduction scheme, Creditors, Pensions, Residential care homes, Payroll
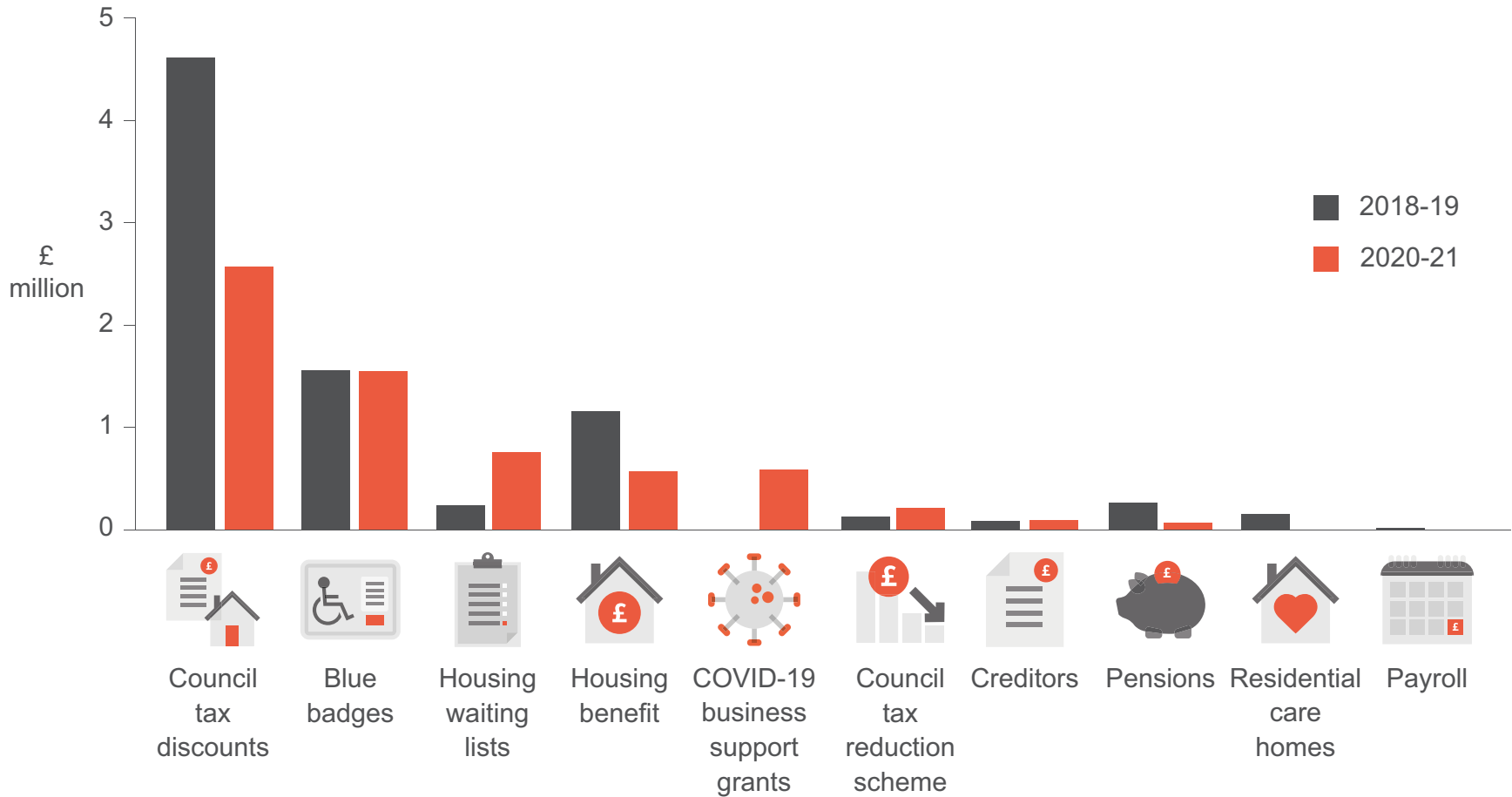
Key messages

Seven areas generated almost 98% of outcomes

The areas which generated the most outcomes from the current exercise are as follows:

Outcomes

Category	£	Cases
Council tax discounts	£2.6m	1,987
Blue badges	£1.4m	2,717
Housing waiting lists	£0.8m	237
Housing benefit	£0.6m	84
COVID-19 business support grants	£0.6m	43
Council tax reduction scheme	£0.2m	214
Creditor payments	£0.1m	9

Results

Process

Once overpayments have been identified, public bodies can take appropriate action to recover the money. As at 31 March 2022, 81% of overpayments had been recovered or were in the process of being recovered.

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Results

Council tax discounts

Key messages

Outcomes

Results

Process

People living on their own, or with no countable adults in the same household, are eligible for a 25% single person discount (SPD) on their annual council tax bill.

Council tax SPD data is matched to electoral register data to help find where people are receiving the discount, but are not the only countable adult at their residence.

The 2020-21 NFI exercise found that the total council tax discount incorrectly awarded across Welsh local authorities totalled £2.6 million. This is an average outcome of £1,305 for each case (£1,003 per case in the 2018-19 NFI). Review of the NFI matches led to the cancellation of 1,987 SPD claims.

While the number of fraudulent or erroneous SPD claims detected fell from 3,939 to 1,987 in the current exercise, this is partly due to investigation of the matches being delayed due to the COVID-19 pandemic. Many claims have been cancelled since the cut-off date for reporting the NFI 2020-21 exercise and these 'late results' will be reported within NFI 2022-23.

Outcomes of **£2.6 million** in 2020-21
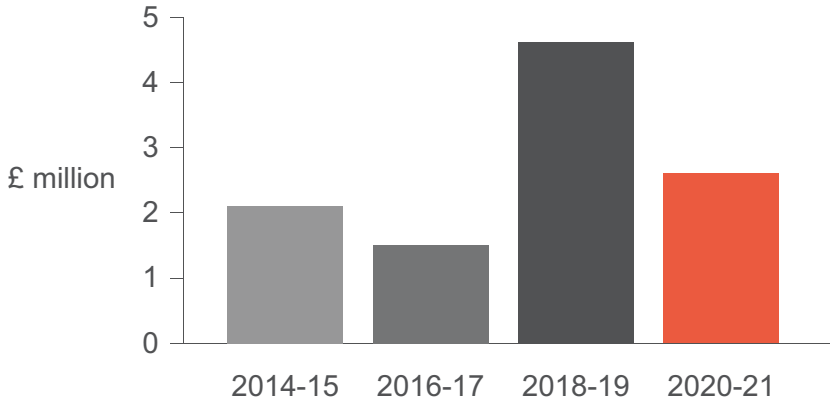
£ million — bar chart: 2014-15, 2016-17, 2018-19, 2020-21

1,987 cases in 2020-21
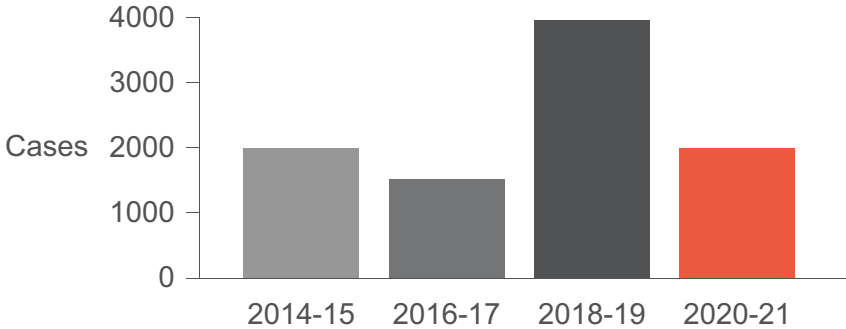
Cases — bar chart: 2014-15, 2016-17, 2018-19, 2020-21

Pensions

The NFI provides local authorities that administer pensions with an efficient and effective way of checking that they are only paying people who are alive.

The exercise found nine instances where pensions had remained in payment after pensioners had died compared to ten cases in NFI 2018-19.

In total, pensions outcomes for the 2020-21 NFI exercise are £0.073 million.

This is a reduction of £0.26 million from the 2018-19 NFI exercise, and reflects the continuing impact of the 'tell us once' reporting process which is ensuring that local authorities become aware of the decease of pensioners earlier. While the number of cases detected by NFI has remained almost unchanged from NFI 2018-19, the average value of each case has fallen from £26,396 to £8,160, because the period of time pensions remained in payment after pensioners' death was shorter.

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Outcomes of **£0.073 million** in 2020-21
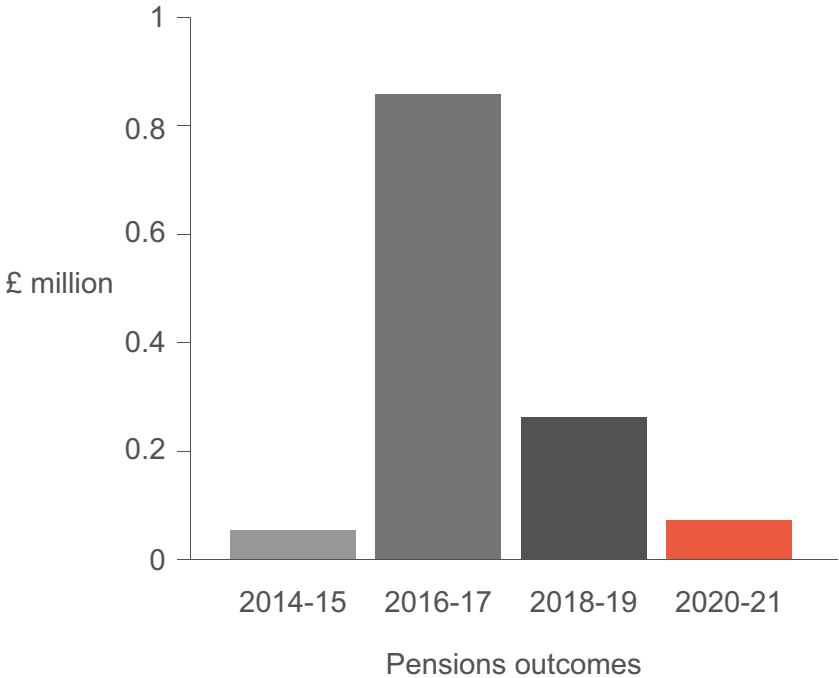
£ million

Pensions outcomes

Key messages

Outcomes

Results

Process

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Housing benefit

The NFI provides local authorities and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors.

Housing benefit data is matched to student loans, payroll, pensions, housing benefit, housing tenants, licences, deceased person and Amberhill* data to help identify ineligible claims.

The value and number of housing benefit cases recorded with overpayments has reduced from £1.2 million (179 cases) in the 2018-19 exercise to £0.6 million (82 cases) in the 2020-21 exercise.

The fall in housing benefit cases outcomes is mainly due to matches between housing benefit and payroll and pension payments not being included in the 2020-21 exercise. These matches historically identified significant outcomes. These matches were not included as similar data matching is undertaking by the DWP's Verify Earnings and Pensions (VEP) Alerts service which identifies discrepancies between payroll and pension details held by HM Revenue & Customs and council benefits services. Alerts from VEP are sent to local authorities to investigate discrepancies.

*Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Outcomes of **£0.6 million** in 2020-21
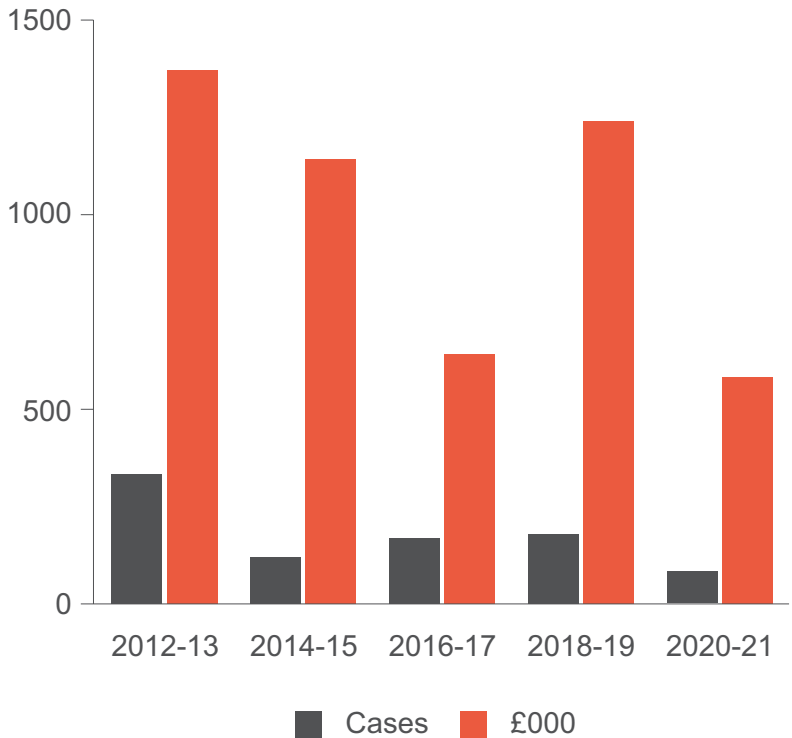
The majority of fraudulent and erroneous claims for housing benefit detected by local authorities in the 2020-21 exercise related to students who were in receipt of housing benefit when not entitled.

Key messages

Outcomes

Results

Process

Case Study: Housing benefit

Carmarthenshire County Council

The Council continues to recognise the value of NFI in protecting the public purse against the threat of fraud risks and considers NFI as being invaluable in the detection and prevention of fraud. The NFI 2020-21 exercise identified 33 housing benefit to student loan matches and of these 13 were high risk matches. Historically the Council has achieved significant results from this specific report and, as in previous exercises, extended the checking process to all matches. Review of the report identified fraud in 30% of the matches, where it was established that benefit customers had failed to declare they were in receipt of student finance/loans. These ten investigations identified overpayments of benefits in excess of £33,000. The Council has recovered the overpayments or remains in the process of full recovery.

Key messages

Outcomes

Results

Process

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Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in pay and display bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

Blue badge data is matched to deceased persons and Amberhill data.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

NFI 2020-21 resulted in the cancellation of 2,717 blue badges in Wales. The number of badges cancelled has increased in each NFI exercise since NFI 2012-13. The estimated value of these cases is £1.4 million based on a calculation of the annual estimated cost of lost parking revenue and the likelihood of these blue badges being misused.

The increase in outcomes is due to a growing recognition of the need to prevent misuse of blue badges. Not only does such misuse reduce parking revenues, it also limits the parking facilities available to genuine blue badge holders.

2,717 outcomes in NFI 2020-21
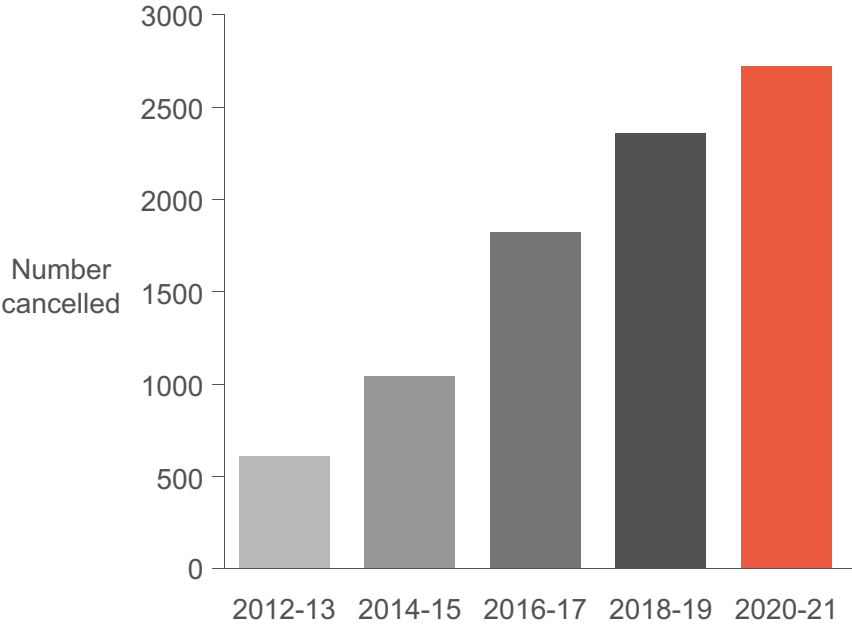
Number cancelled

Year	Number cancelled (approx)
2012-13	600
2014-15	1050
2016-17	1800
2018-19	2350
2020-21	2717

Key messages

Outcomes

Results

Process

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Housing waiting lists

NFI uses housing waiting list data to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016-17 NFI exercise.

Housing waiting list data is matched to waiting list, housing benefit, housing tenants, deceased persons and Amberhill data.

Local authorities identified 237 cases where applicants were removed from waiting lists compared to 74 cases in 2018-19.

The estimated value of these cases is just under £0.8 million based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided with a property.

The increase in the number of applications cancelled is due to increased efforts by local authorities to review the NFI matches thereby helping ensure that social housing is only provided to eligible persons.

Number of applicants removed from housing waiting lists

Number of cases

250
200
150
100
50
0

2016-17   2018-19   2020-21

NFI excercise
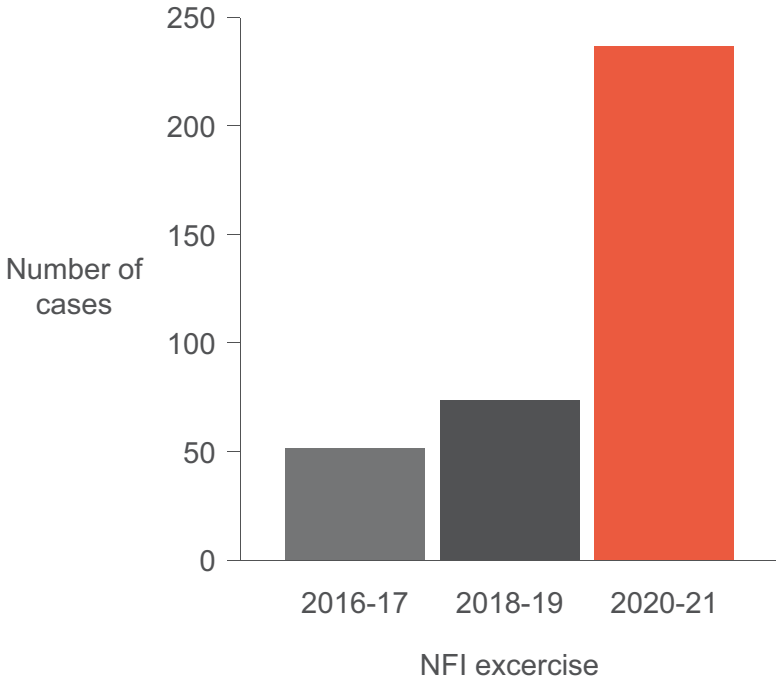
Key messages

Outcomes

Results

Process

Creditor payments

The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors.

Creditor payment data is also matched to payroll and Companies House data to help identify undisclosed staff interests in suppliers.

NFI 2020-21 resulted in 54 creditor payment outcomes totalling just over £0.1 million compared to 53 outcomes totalling just under £0.1 million in NFI 2018-19. Recovery action has already taken place or is in process for all of these overpayments.

Creditor payment outcomes have reduced over NFI exercises as participating bodies have improved their internal control systems.

Outcomes of **£0.1 million** in 2020-21
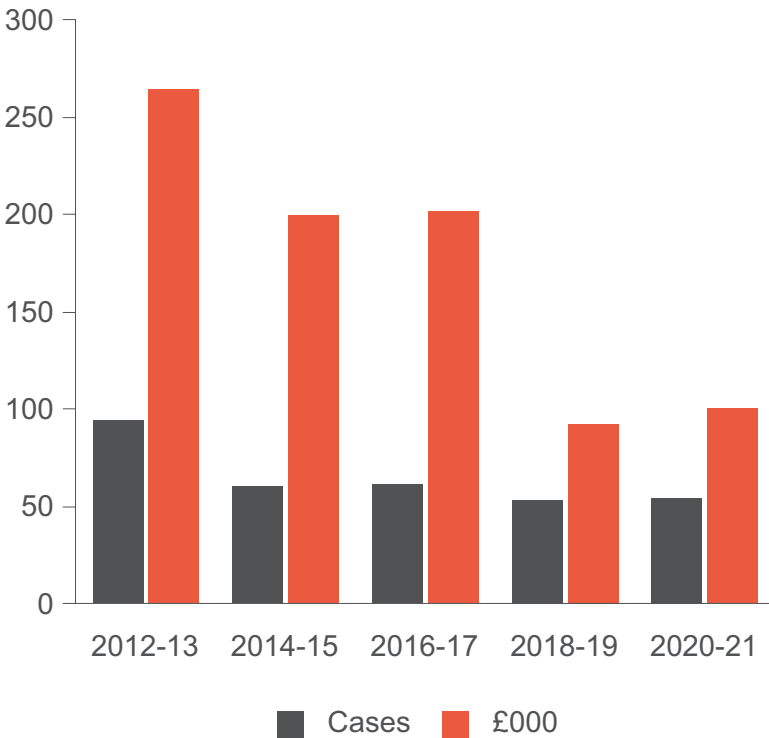
Legend: ■ Cases ■ £000

Key messages

Outcomes

Results

Process

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Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills.

The NFI provides local authorities with the opportunity to identify a range of council tax reduction frauds and errors.

Council tax reduction data is matched to council tax reduction, payroll, pensions payroll, housing benefits, housing tenants, licences, deceased persons and Amberhill data.

The 2016-17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.21 million were identified in the 2020-21 NFI and claims for council tax reduction were amended or cancelled in 214 cases.

The average value of each case was £1,015 compared to £1,457 in NFI 2018-19 suggesting that fraud and error is being identified earlier.

Outcomes of **£0.21 million** in 2020-21
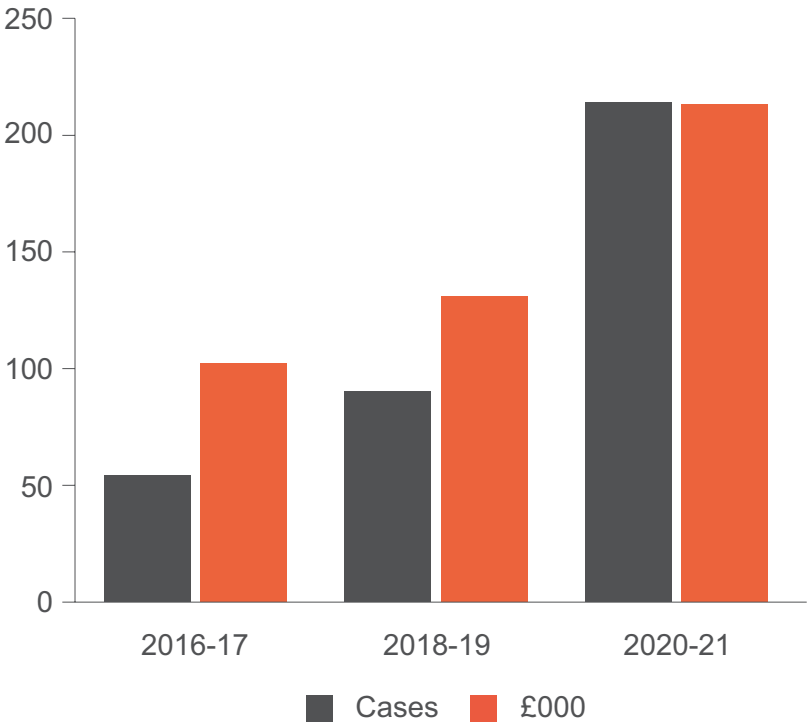
Cases   £000

2016-17   2018-19   2020-21

Key messages

Outcomes

Results

Process

Case study: Vale of Glamorgan Council

The Council has a proactive and comprehensive approach to reviewing all NFI matches. All council tax reduction matches are reviewed by the Investigation Officer against the Council's internal systems to try and establish the current household status of claimants. One such match appeared to show the claimant had not declared an occupational pension that had been in payment since 2018. The Investigation Officer advised the Benefits Team that further investigation was required. The Benefits Team liaised with the Revenues Team and found there was another person residing at the address who was also in receipt of an undeclared occupational pension and who had received a substantial lump sum pension payment in 2018. Despite numerous attempts to verify the current situation with the claimant, the claimant failed to respond. The Council has cancelled the claim and the claimant has agreed to repay an overclaim of £4,775 in monthly instalments.

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Use of HMRC Data in NFI

In NFI 2020-21, for the first time, Welsh NFI matches were enriched by HMRC data provided under the provisions of the Digital Economy Act 2017. The HMRC data is proving highly effective in helping to identify applicants who have claimed means-tested benefits and discounts but have not declared income that should have been declared on their applications.

Case Study: Denbighshire County Council

The Council proactively reviewed matches between Council Tax Reduction Scheme (CTRS) and HMRC's household composition. One match suggested there was an undeclared non-dependant in the household from 2017, so benefit payments were suspended. The Benefits Team had previously been notified that the person had left the household in March 2017. On investigation, the customer confirmed the failure to declare the non-dependant since May 2017. The NFI match showed the earnings of the non-dependant to be around the threshold at which the highest deduction to the claimant's benefits would apply, so in the absence of further evidence of the non-dependent's income, the is highest deduction was applied. This resulted in an overclaim totalling £20,782. The Council is in the process of recovering the overclaim.

Key messages

Outcomes

Results

Process

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COVID-19 business support grants
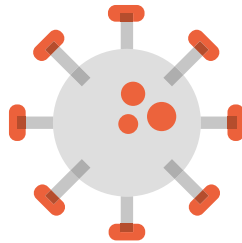
In response to the COVID-19 pandemic, the Welsh Government put in place a package of measures to support businesses through the crisis. One of these measures included providing grant funding through Welsh local authorities to some retail, hospitality and leisure businesses and to businesses classified as small businesses for business rate purposes. NFI matched these grants to ensure that businesses were not inappropriately claiming multiple grants and that grants were not being awarded to known fraudsters. These checks only identified two cases of fraud and error amounting to £20,000, providing assurance that these practices were not common.

NFI also made optional tools available to local authorities to confirm that grant applicants were actively trading before the COVID-19 pandemic, and that bank account details provided by applicants related to legitimate business accounts. One Welsh local authority, Cardiff Council, used these tools in conjunction with other internal controls to identify 41 cases of fraud and error with a value of £575,000.

Case Study: Cardiff Council

Following the use of various upfront application and payment controls, the Council used a multi-layered approach to post payment verification and assurance processes for COVID-19 business support grants. NFI provided a useful source of intelligence as part of these post payment checks. The Corporate Fraud Investigation Team and colleagues in Business Rates used a range of investigative techniques and identified £575,000 of payments for recovery. For example, one NFI match indicated that a company had ceased trading, online enquiries suggested the business had closed and a Companies House check showed the company had dissolved prior to the grant eligibility date. The company had not notified the Council that they had ceased trading and were not eligible for the grant. The Council has recovered, or is is seeking to recover the overclaims wherever there is a realistic chance of doing so.

Key messages

Payments to residential care homes

Outcomes

In previous NFI exercises, NFI has matched residential care home data to deceased persons to identify cases where a care home resident has died, but the local authority has not been notified and so has continued to make payments to the care home.

In NFI 2018-19, 11 cases of overpayments were identified where Welsh local authorities were continuing to pay care homes for residents who had died. The average value of these cases was £14,545.

Results

Due to the unintended consequence of a change to legislation affecting Wales, Scotland and England, it was not possible to undertake matching in this area as part of NFI 2020-21. The Auditor General is working with the Cabinet Office and Audit Scotland to find a legislative solution that will allow this matching to be undertaken in future NFI exercises.

Process

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Key messages

Outcomes

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Process

Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Welsh participants for the 2020-21 NFI exercise helped other public bodies outside Wales identify outcomes worth just over £183,000.

Most of these outcomes relate to housing benefits, housing waiting lists, and council tax reductions. For example, payroll data from a health board may allow a local authority to identify a housing benefit overpayment.

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that providing their data can help other bodies and sectors identify frauds and overpayments.

Sector of source data	£	Number of outcomes
Local authorities	162,776	135
NHS	15,811	17
Fire	4,458	1
Total	**183,045**	**153**

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Process

The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Auditor General, Cabinet Office, Audit Scotland, and the Northern Ireland Audit Office lead the exercise in Wales, England, Scotland, and Northern Ireland, respectively. The NFI takes place biennially and enables public bodies to use computer data matching techniques to detect fraud and error.

The main purpose of the NFI is to ensure funds and services are provided to the correct people, but the NFI can also identify individuals entitled to additional services or payments eg housing benefit matches may identify customers entitled to council tax discount or reduction.

We carry out the NFI process under powers in the Public Audit (Wales) Act 2004. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls governing the NFI data matching exercise.

In Wales, the Auditor General has mandated unitary local authorities and NHS bodies to participate in the NFI. The Welsh Government, some Welsh Government Sponsored Bodies, and Audit Wales participate on a voluntary basis.

The biennial NFI exercise

NFI exercise conducted every 2 years across the UK and in Wales by the Auditor General

Participants submit data to a secure website

The NFI system matches data in and between bodies to identify anomalies

Potential anomalies called 'matches' are reported to participants to review, investigate and record outcomes

Auditors monitor participants processes and progress

NFI outcomes are reported by individual participants and nationally by the Auditor General

Key messages

How bodies work with the NFI

Outcomes

The success of the NFI is dependent on the proactivity and effectiveness of participant bodies in investigating the data matches.

Most participating Welsh public bodies managed their roles in the 2020-21 NFI exercise well.

Results

However, some bodies could be far more pro-active in their approach to the NFI. In particular, some local authorities reviewed very few of the matches they received, and as a consequence did not do sufficient work to address potential frauds. This was due to some participants failing to recognise the importance of the exercise and/or an unwillingness to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

Process

Key messages

Outcomes

Results

Process

Future developments

- The Auditor General is considering how to further develop the scope of NFI in Wales and areas of potential data-matching currently being explored include, housing tenancies, GP patient registration, business rates.

- The 2022-23 NFI is now underway. Data sets have been reviewed following a period of consultation and NFI participants are starting to submit data for matching.

- The Auditor General continues to work with the Welsh Government to promote and enhance participation in the NFI across Wales.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes the National Fraud Initiative in Wales under Part 3A of the Public Audit (Wales) Act 2004 which empowers him to conduct data matching exercises for the purpose of assisting in the prevention and detection of fraud in or with respect to Wales and to publish the results of any such exercise.

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 umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to provide staff and to monitor and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales

24 Cathedral Road

Cardiff, CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in
Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

Equality Impact Assessments: more than a tick box exercise?

Report of the Auditor General for Wales

September 2022
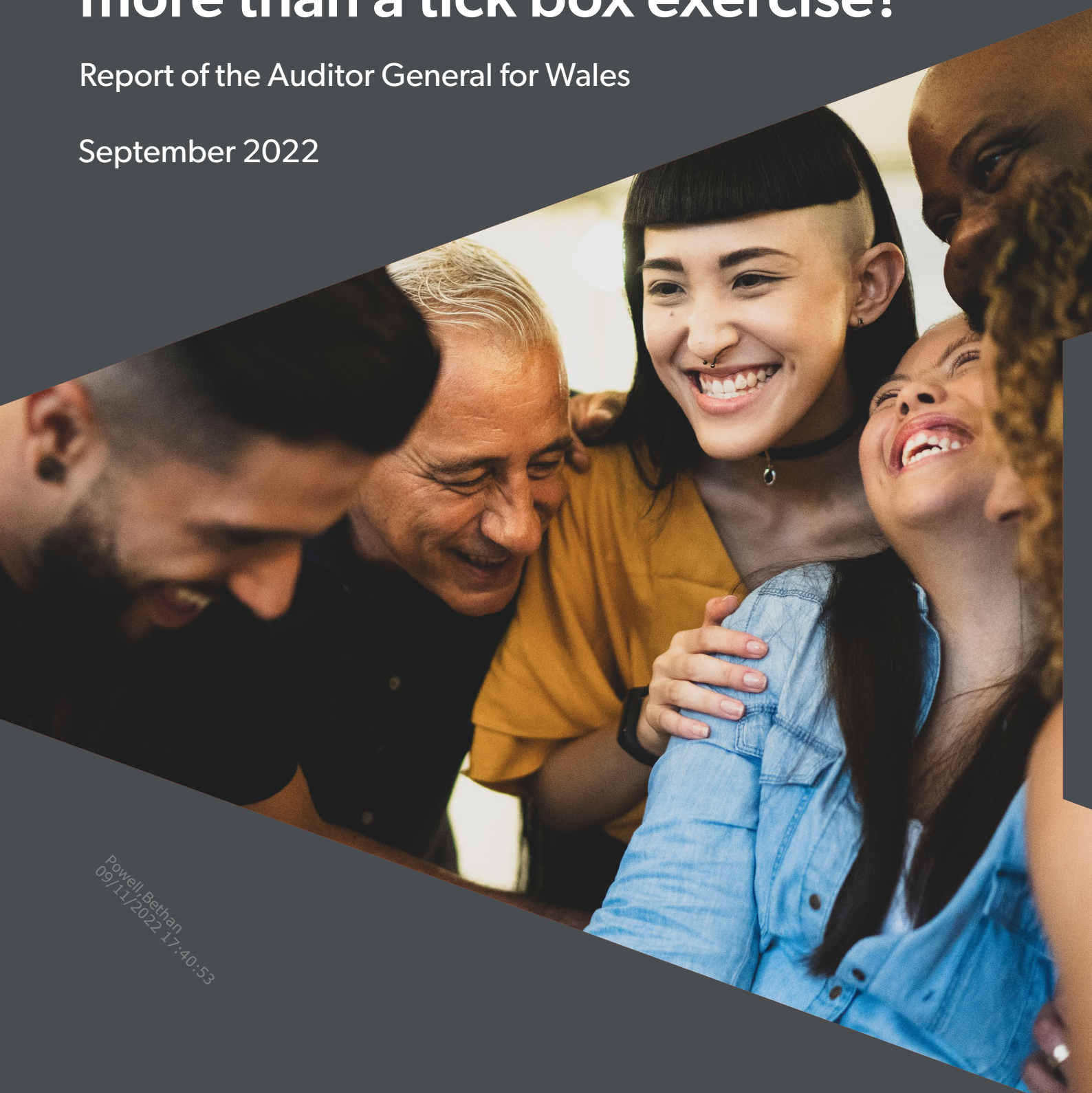
This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

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Detailed report

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◀ **Auditor General's foreword**

Discrimination and inequality continue to impact on the quality of life and life chances of people in Wales. My Picture of Public Services 2021 report highlighted that the COVID-19 pandemic had amplified some of the entrenched inequalities in our communities. Black Lives Matter, MeToo and other social movements have brought issues of discrimination and inequality to the forefront of public policy and debate.

Equality Impact Assessment (EIA) is an important part of the approach to tackling inequality in Wales. EIAs help public services meet their legal duties to avoid discrimination in the decisions they make and to promote equality of opportunity and cohesion.

Done well, EIAs are more than a means to show compliance. They support the growth of a mind-set and culture that put issues of equality at the heart of decision-making and policy development.

Our work shows that within individual public bodies there are good examples of aspects of the process of conducting an EIA. Through this report, I want to help all public bodies learn from those that are doing well and trying new approaches.

However, what we have seen and heard tells us that public bodies in Wales tend to use their EIAs defensively. Too often, they seem like a tick box exercise to show that the body has thought about equality issues in case of challenge. While legal challenge is of course an important risk to manage, this approach means public bodies are not using EIAs to their full potential, especially in terms of promoting equality and cohesion.

I hope this report will be of interest to anybody involved in public services and with an interest in tackling inequality and promoting equality. However, I want this work to be more than interesting. It needs to have an impact. Specifically, I expect:

- the Welsh Government to respond to the recommendations to work with partners to improve and update the overall approach to EIAs;

- all public bodies to respond to the recommendation that they review their own approaches to EIAs, including mindset and culture, drawing on the findings of this report; and

- those involved in scrutiny to use this report to challenge their organisation's overall approach to EIAs and the quality of individual EIAs used to inform their decisions.

I am pleased to say that this work has already had positive impacts. Our fieldwork questions have prompted some public bodies to check aspects of their own arrangements. And we have shared emerging findings with some public bodies that were updating their approach to EIAs. Closer to home, at Audit Wales, we are looking closely at our own processes and procedures to reflect the lessons identified in this work.

Adrian Crompton
Auditor General for Wales

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◀ Key facts

We set out below some key facts about the population in Wales in the context of the nine protected characteristics under the Equality Act 2010.

26,754 pregnancies during 2021[8]

16.5% aged under 15[1]

3.9% people who identify as gay, lesbian, bisexual or other[6]

7.8% people from a Black, Asian or minority ethnic community[5]

50.1% people with religious belief[4]

22.1% 16 to 64 year-olds identifying as disabled[2]

51.1% women[1]

48.1% people aged 16 and over who are married or in a civil partnership[3]

59% of transgender women and **56%** of transgender men said they avoided expressing their gender identity for fear of a negative reaction from others (UK)[7]

21.3% aged 65 and over[1]

65+

3,107,500 population of Wales[1]

Sources:

1 Office of National Statistics (ONS), Population and household estimates, Census 2021, June 2022

2 StatsWales, Disability by age and sex (Equality Act definition) (2018-2020)

3 StatsWales, Marital status by age and sex (2018-2020)

4 StatsWales, Religion status by age (2018-2020)

5 ONS, Population estimates by ethnic group, England and Wales December 2021 (data for 2019)

6 StatsWales, Sexual identity by year, 2019

7 Government Equalities Office, National LGBT Survey, July 2018 (survey ran for 12 weeks from July 2017)

8 StatsWales, Initial assessment indicators for Wales, by mother's age, 2021

◀ **Key messages**

Context

1   Tackling inequality is a long-standing goal of the Welsh Government.
     It features prominently in the 2021-2026 Programme for Government
     which includes the objective to 'celebrate diversity and move to eliminate
     inequality in all of its forms'[1]. The Well-being of Future Generations
     (Wales) Act 2015 makes 'A more equal Wales' a national goal. It defines
     this as 'a society that enables people to fulfil their potential no matter
     what their background or circumstances (including their socio-economic
     background and circumstances)'.

2   Equality Impact Assessment (EIA) is an important part of the approach
     to tackling discrimination and promoting equality in Wales. The Equality
     Act 2010 introduced the Public Sector Equality Duty (PSED) across Great
     Britain (**Exhibit 1**). The Welsh Government has made its own regulations[2]
     setting out some Wales specific duties that bodies listed in the Act need
     to follow to meet the PSED. Public bodies subject to the Act must assess
     the likely impacts of proposed policies or practices or proposed changes to
     existing policies or practices on their ability to meet the PSED. In doing so,
     they must comply with specific requirements to engage with groups likely
     to be impacted and monitor actual impacts.

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1   Welsh Government, Programme for Government: update, December 2021
2   The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

Exhibit 1: the Public Sector Equality Duty and protected characteristics

The PSED requires public bodies, in exercising their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation, and any other conduct prohibited by the Act;

- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Act and the Wales specific duties apply to public bodies including councils, NHS bodies, fire and rescue services, national parks, education bodies (further and higher education bodies and maintained schools), and the Welsh Government and some of its sponsored bodies.

3   An EIA can provide evidence that the body has met the PSED. There have been legal challenges to decisions based on the lack or adequacy of an EIA. Moreover, EIAs support good policy and decision-making more generally by:

- **ensuring decisions impact protected groups in a fair way** – EIAs can demonstrate what, if any, action could be taken to mitigate the impact on one or more protected groups negatively affected by a decision and to promote equality and cohesion;

- **support evidence-based policy or decision-making** – EIA is a clear and structured way to collect, assess and present relevant evidence to support decisions; and

- **making decision-making more transparent** – EIAs must be published where they show there is or is likely to be a substantial impact.

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4   As well as the PSED, the Equality Act 2010 included provision for a new
       socio-economic duty for public bodies[3]. The socio-economic duty came
       into force in Wales on 31 March 2021. It requires that public bodies, 'when
       making decisions of a strategic nature about how to exercise its functions,
       have due regard to the desirability of exercising them in a way that is
       designed to reduce the inequalities of outcome which result from socio-
       economic disadvantage'. The Welsh Government advises public bodies to
       consider the socio-economic duty as part of existing processes, including
       impact assessments. We are currently reviewing local government's work
       to tackle poverty, including aspects of the socio-economic duty and the
       lived experience of people experiencing poverty.

About this report

5   We looked at the overall approach to undertaking EIAs in public bodies
       in Wales. To focus our work, we concentrated on the 44 public bodies
       originally subject to the Well-being of Future Generations (Wales) Act
       2015. The main groups covered by the PSED that we did not include
       were the education bodies – further and higher education institutions and
       maintained schools – and Corporate Joint Committees.

6   We focused primarily on understanding public bodies' approaches with a
       view to finding good or interesting practice and identifying any common
       areas for improvement. We did not evaluate individual public bodies'
       approaches in detail. **Appendix 1** has more detail on our audit approach
       and methods. Where we identify individual bodies' practices, this is not to
       say that they are necessarily alone in having good or interesting practices
       in that area.

7   Parts one to three of this report set out the findings from our consideration
       of the EIA process at the 44 public bodies. Below, we set out the main
       areas for improvement we identified. These include issues that go beyond
       how public bodies are conducting specific parts of the processes and offer
       insight about the overall approach to assessing the impacts of policies and
       practices and the underpinning mindset and culture.

8   The Welsh Government is currently reviewing the PSED Wales
       specific regulations. We have framed our key improvement areas and
       recommendations in the context of the opportunity the review offers to
       clarify aspects of the overall approach to EIAs in Wales.

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3   The duty lay dormant on the statute book as the UK Government did not commence it. The
     Wales Act 2017 gave new powers to the Welsh Ministers and allowed them to commence the
     duty in Wales. It covers most types of public bodies subject to the PSED.

Key improvement areas

9   Positively, there are examples of good practice in aspects of the EIA
     process across the public bodies we looked at. There is also non-statutory
     guidance from the Equality and Human Rights Commission (EHRC)[4] and
     on the Equality Impact Assessment In Wales Practice Hub (the Practice
     Hub) about the detailed processes for conducting an EIA. Many public
     bodies use this guidance to shape their approaches. However, there are
     areas for improvement (**Exhibit 2**).

Exhibit 2: key improvement areas for EIA

	Greater clarity over which type of policies and practices must be impact assessed
	Greater clarity about the arrangements for assessing the impact of collaborative policies and practices
	Greater clarity about expectations to consider the PSED as part of an integrated impact assessment
	Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect
	More engagement and involvement of people with protected characteristics
	Better monitoring of the actual impacts of policies and practices on people
	A shift in the mindsets and cultures to move EIA away from being seen as an add-on 'tick box' exercise

4   Equality and Human Rights Commission, Assessing Impact and the Equality Duty: A Guide
     for Listed Public Authorities in Wales, October 2014; and Equality and Human Rights
     Commission, Technical Guidance on the Public Sector Equality Duty: Wales, August 2014.

Greater clarity over which type of policies and practices must be impact assessed

10   There is scope for the Welsh Government, working with partners, to clarify its expectations around which type of policies and practices must be impact assessed. As drafted, the Welsh specific duties require public bodies to assess all new policies or practices, or those under review. However, the EHRC's non-statutory guidance recognises that 'policies and practices' is a broad category and says public bodies may need to prioritise. It introduces the concepts of 'proportionality' and 'relevance', which it says public bodies can apply through a process known as 'screening'.

11   We think the current position is open to interpretation in terms of whether proportionality and relevance mean public bodies should: (a) prioritise big decisions, like budget decisions or major service change; or (b) prioritise decisions that are likely to have a big impact on certain groups, for example, small scale decisions could have a large impact on one section of the population. Further, many bodies have interpreted proportionality as determining the amount of work needing to be done to assess impacts, rather than whether a policy or practice needs an EIA.

12   The EIAs or screening decisions that public bodies publish are usually those that go to their boards or cabinets. They therefore tend to be at the more strategic or impactful end of the scale. While we did not examine in detail practices at individual bodies, we think there is a risk that public bodies may be informally filtering out smaller scale policies and practices that do not require decisions from boards or cabinet, even though they may impact on people with protected characteristics.

Greater clarity about the arrangements for assessing the impact of collaborative policies and practices

13   There is scope to clarify how public bodies should do EIAs in an environment of increasing collaboration. The law places duties on individual public bodies. Since the legislation came into force, public bodies are increasingly developing plans and delivering services through collaborative arrangements. The Welsh Government updated the legislation to extend the PSED and Wales specific duties to Corporate Joint Committees in local government, but there are other collaborative arrangements not covered. These include Public Services Boards and Regional Partnership Boards as well as multiple service specific collaborations.

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14   The Welsh Government has not produced stand-alone guidance on the use of EIAs by collaborative arrangements, although guidance for Public Services Boards highlights EIA requirements for individual public bodies[5]. The EHRC's 2014 guidance predates the creation of many of these arrangements and offers high level advice that there should be a shared approach but does not say how this should work in practice.

Greater clarity about expectations to consider the PSED as part of an integrated impact assessment

15   Increasingly, public bodies are integrating their EIAs with other impact assessments. While there is no legal requirement to integrate assessments, the Welsh Government's guidance on the Well-being of Future Generations (Wales) Act[6] emphasises the opportunities for bodies to integrate their approach to different duties, including those under the Equality Act 2010. Many of the equality officers[7] we spoke to said that integrating impact assessments led to a streamlined process and a more rounded approach to thinking about impacts. The key downside can be that the assessment is longer and can appear daunting. Our review of EIAs also identified a risk that integrated impact assessments dilute the focus on the impacts of policies and practices on people with protected characteristics.

16   Public bodies are inconsistent in what they include in an integrated impact assessment. Mostly, they collate separate assessments in one document, rather than produce a truly integrated analysis of impacts. There is no specific guidance to support public bodies in conducting integrated impact assessments. Many equality officers would welcome clearer guidance from the Welsh Government about its expectations.

Better and more timely identification of the practical impacts of decisions on people and how different protected characteristics intersect

17   There are examples of EIAs that clearly identify likely impacts on groups of people. However, many EIAs we reviewed were descriptive. They identified that a policy or practice might impact on a group of people. But they did not show how it would impact people's lives in practice. This makes it more difficult for decision-makers to assess how important the likely impacts are and if any mitigating measures proposed would be sufficient.

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5   Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 3: Collective Role (public service boards)), February 2016.

6   Welsh Government, Shared Purpose: Shared Future Statutory Guidance on the Well-being of Future Generations (Wales) Act 2015 (SFSP 2: Individual Role (public bodies)), February 2016.

7   We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

18   In general, public bodies tend to identify negative impacts that they need
      to mitigate where possible. They are less likely to identify potential ways
      that the policy or practice could positively promote equality of opportunity
      and cohesion, even though this is a requirement of the PSED.Few public
      bodies have fully grasped the complexity of identifying likely impacts of
      policies and practices. None of the EIAs we looked at considered what is
      known as 'intersectionality'; the way that different protected characteristics
      combine. For example, while an EIA may identify impacts for Muslim
      people, it may not recognise that impacts could be very different for a
      Muslim woman compared to a Muslim man.

19   Many public bodies are thinking about how to identify the cumulative
      impacts of multiple decisions but few are doing so. Most do not have
      supporting systems that would enable those conducting EIAs to access
      the information needed about other decisions.

20   Most public bodies' formal processes and guidance say they will start
      thinking about impacts very early in the policy development process.
      However, many of the equality officers recognised that in practice EIAs
      often start late in the process, sometimes very shortly before a decision
      is due to be taken. This reduces the scope to shape the policy or practice
      and to mitigate impacts.

More engagement and involvement of people with protected characteristics

21   There are examples of public bodies seeking views from people with
      protected characteristics and drawing on their lived experience as part of
      the EIA. However, some third sector bodies are concerned that this does
      not happen nearly enough. We found that where public bodies seek views
      these often form part of a broader open consultation rather than focussing
      on specific groups with protected characteristics.

22   Some third sector organisations said that listening to people with protected
      characteristics was the action that would most improve EIAs. National
      representative public bodies could not always respond to the number
      of requests to take part in EIAs they receive and did not always have
      knowledge or information to respond to local issues.

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Better monitoring of the actual impacts of policies and practices on people

23   Public bodies need to do more to monitor the impact of policies or
      decisions on protected groups. Equality officers at individual public bodies
      identified very few examples of public bodies monitoring the actual impacts
      of a policy or decision once implemented. Those examples put forward
      generally reflected broader monitoring of a policy's objectives rather than
      whether the impacts identified in the EIA materialised or whether there
      were other unanticipated impacts.

**A shift in the mindsets and cultures that moves EIA away from being seen as an
add-on 'tick box' exercise**

24   From what we have seen there has not been a sufficient change in the
      mindset and culture in public services to put issues of equality at the heart
      of policy making. The mindset revealed by the EIA is often defensive:
      using EIAs to prove the body has paid due regard to equality in case of
      political or legal challenge. Often, the EIA seems like an additional 'tick
      box' exercise to be complied with rather than a tool to promote equality.

◀ **Recommendations**

Recommendations

Clarifying the scope of the duty to impact assess policies and practices

R1   There is scope for confusion about which type of policies and practices must be subject to an assessment for their impact on the public sector equality duty. **The Welsh Government should clarify its interpretation of the duty, including whether and how it expects public bodies to apply any test of proportionality and relevance.**

Building a picture of what good integrated impact assessment looks like

R2   Many public bodies carry out integrated impact assessments that include consideration of the PSED alongside other duties. But practice is inconsistent and often involved collating multiple assessments in one place, rather than being truly integrated, **to help maximise the intended benefits of integrated impact assessments, the Welsh Government should work with key stakeholders with an interest in the areas commonly covered by integrated impact assessments and those with lived experiences, to share learning and work towards a shared understanding of what good looks like for an integrated impact assessment.**

Recommendations

Applying the equality duties to collaborative public bodies and partnerships

R3   The public sector landscape has changed since the introduction of the PSED and the Welsh specific duties, with an increasing focus on collaborative planning and delivery. **The Welsh Government should review whether it needs to update the Wales specific regulations to cover a wider range of collaborative and partnership arrangements. These include public services boards, regional partnership boards and other service specific partnerships.**

Reviewing public bodies' current approach for conducting EIAs

R4   While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. **Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.**

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Supporting arrangements for conducting EIAs

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1.1   Conducting an EIA can be complicated. Good support can help make the
      process of conducting EIAs easier and more effective by having a clearly
      spelled-out approach and process, underpinned by clear guidance and
      training. And public bodies can have expert advice to hand to support
      those involved in assessing the impacts of decisions.

Setting out the organisation's approach to EIA

What we looked for

A clearly spelled-out approach to EIA for the organisation, including
whether the EIA should form part of a wider integrated impact assessment.

What we found

Almost all public bodies had a set process for conducting an EIA, although
these vary from a stand-alone EIA to producing integrated impact
assessments covering a wide and varying range of other legal duties
and policy priorities.

Strategic equality plans

1.2   All 44 public bodies met the requirement to produce a Strategic Equality
      Plan (SEP). The SEP must include an organisation's equality objectives,
      how they will measure progress on meeting objectives, and how they will
      promote knowledge and understanding of the general and specific duty.
      The SEP must also set out the public bodies' arrangements for assessing
      the likely impact of policies and practices on their ability to meet the PSED.
      However, in our review of SEPs we found that only 17 of the 44 bodies did
      so and to varying degrees of detail.

1.3   A few public bodies have gone further than simply describing
      arrangements. For example, Conwy County Borough Council's SEP
      describes in detail its process for EIA, how its Cabinet uses EIAs to
      support decision-making, and scrutiny committees' role in ensuring the
      quality of EIAs. The Council's SEP also explains how it has used EIAs to
      inform its equality objectives.

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Organisational approach – integrated and stand-alone assessments

1.4   Nearly all public bodies (42 of 44) have a set process for undertaking EIAs. Most said that they put information on intranet sites, alongside supporting documents, contacts and most often a Word template for completion. Our review of EIAs found no standard format across public bodies, although most closely followed the approach set out in the Practice Hub. Members of the North Wales Public Sector Equality Network[8] have worked together to develop a standard template which most members of the network have adopted at least in part.

1.5   In around two-thirds (30 of 44) of public bodies we spoke to, the EIA forms part of a wider integrated impact assessment. There is no common approach to integrated impact assessments and no national guidance on what should be covered. There are some assessments that public bodies commonly include alongside the PSED (**Exhibit 3**). Some include other legal duties as well as policy priorities and practical considerations, such as finance. For example, the Welsh Government's integrated impact assessments sometimes cover climate change impacts, health impacts and economic impacts as well as a wide range of other legal duties, depending on the nature of the policy or practice.

8   The North Wales Public Sector Equality Network is an informal network of public bodies working together to advance equality. Representation includes North Wales local authorities, Betsi Cadwaladr University Health Board, North Wales Police and Police Authority, North Wales Fire and Rescue Service, Welsh Ambulance Services NHS Trust, and Snowdonia National Park Authority.

Exhibit 3: assessments commonly included in an integrated impact assessment alongside the EIA

Well-being of Future Generations	The Well-being of Future Generations (Wales) Act 2015 introduced seven well-being goals for Wales. It also established the sustainable development principle and five ways of working – long-term, integration, involvement, collaboration, and prevention – to demonstrate application of the principle. An integrated impact assessment may also include an assessment of the policy or practice against the seven goals, public bodies' individual well-being objectives and/or the five ways of working specified in the Act.
Welsh Language	The Welsh Language (Wales) Measure 2011 declares that the Welsh language has official status in Wales. It makes provision to promote and facilitate the use of the Welsh language and to treat Welsh no less favourably than English through the Welsh language standards. Part of applying the standards means that public bodies must consider the effects their policy decisions on the Welsh language.
Environmental impacts	There are various duties to carry out environmental impact assessments depending on the nature of the proposed policy or practice. These range from strategic assessments of plans and programmes to assessments of projects that potentially impact on habitats and biodiversity.
UN Convention on the Rights of the Child	The Rights of Children and Young Persons (Wales) Measure 2011 embeds consideration of the United Nations Convention on the Rights of the Child and the optional protocols into Welsh law. The UN Convention consists of 41 articles, which set out a wide range of types of rights including rights to life and basic survival needs, rights to development including education and play, rights to protection, including safeguarding from abuse and exploitation, and rights to participation and express opinions.

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| Socio-economic | The Socio-economic duty came into force on 31 March 2021. When making strategic decisions, such as deciding priorities and setting objectives, public bodies must consider how they can reduce inequalities associated with socio-economic disadvantage. |

1.6 Most integrated impact assessments involve collating separate impact assessments into a document template. Few seem to be a truly integrated impact assessment. Some public bodies are trying to make the connections between assessments and reduce duplication. For example, Carmarthenshire County Council, Powys County Council, Gwynedd Council, Denbighshire County Council and Wrexham County Borough Council have each developed, or are developing, an IT solution to bring together the relevant information needed to inform an integrated impact assessment.

1.7 Very few public bodies solely assess the impact on the PSED even when they do not consider their assessments to be integrated. In those public bodies that report having a standalone EIA process, the EIA often also includes Welsh-language and socio-economic impacts.

1.8 Previous research has found length is a barrier to the use of impact assessments in decision-making[9]. It was hard for us to judge any EIA or integrated impact assessment as too long as many factors affect the length including the nature of the policy or decision and the number of assessments undertaken. We reviewed some documents that were very long; for example, the integrated impact assessment of the Welsh Government's remote working policy was 45,000 words (average reading time 2.5 hours). The majority for which a word count was easily identifiable ranged between 2,500 and 7,500 words (average reading time 8 to 25 minutes).

1.9 Most public bodies that have chosen not to integrate their assessments had considered the option. Reasons for not integrating assessments included a concern that there would be insufficient regard to the PSED. This may be a valid concern. Our review suggests that, in some cases, the PSED is covered in limited detail and appeared secondary to other considerations even though all the public bodies we spoke to who conduct integrated impact assessments felt they sufficiently covered the equality element.

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9   Grace, C., Reducing Complexity and Adding Value: A Strategic Approach to Impact Assessment in the Welsh Government, Public Policy Institute for Wales, February 2016.

Specialist support and expertise

What we looked for

That there is specialist support and expertise available in the organisation to those conducting EIAs.

What we found

In most cases, policy leads are responsible for conducting EIAs and can access support from colleagues with knowledge in equality related issues and an in-depth understanding of the organisation's process for conducting an EIA.

1.10   In almost all public bodies, responsibility to undertake an EIA lies with the lead officer developing or reviewing a policy or practice. This is partly pragmatic, due to the number of EIAs public bodies conduct. Equality officers told us this approach meant that EIAs benefitted from policy leads' expertise on the topic area. However, they identified drawbacks, including the difficulty of ensuring consistency, getting EIAs started at the right time and ensuring quality.

1.11   All public bodies have equality officers (or equivalent) with knowledge in general equality issues and a detailed understanding of the organisation's EIA process. In all public bodies, staff conducting EIAs can ask equality officers for guidance when required. EIAs are mostly conducted without the input of an equality officer. The process at Aneurin Bevan University Health Board is one exception to this, where the first step for anyone who thinks they need to undertake an EIA is to contact the Equality Diversity and Inclusion specialist to discuss the proposed policy or practice and agree what actions they need to take, with ongoing support also provided. In smaller public bodies, where an EIA is more likely to relate to staff policies and decisions, the lead for conducting the EIA is frequently an HR officer who is also the equality officer.

Guidance to support those conducting an EIA

What we looked for

That there is guidance to support those conducting an EIA, setting out what they need to do and when, in line with the duties and their organisation's chosen approach.

What we found

There is non-statutory national guidance and support available setting out some good practice in the stages of an EIA, although there are gaps, notably in terms of integrated impact assessments. Most public bodies have also produced their own guidance to support their EIA process.

External guidance

1.12 The Welsh Government has not published statutory guidance on the application of the PSED in Wales or the Welsh specific duties. The EHRC published non-statutory guidance on the Welsh specific duties in 2014. Welsh Government guidance encourages public bodies to integrate different duties. But there is no specific national guidance on how to conduct integrated impact assessments and what should be included.

1.13 The Welsh Government, Welsh Local Government Association, and NHS Centre for Equality and Human Rights jointly developed the Practice Hub in 2015-16. This online resource provides information and support to public bodies in Wales to undertake EIAs. It provides a detailed eight step guide to good practice in undertaking EIA and gives information on the Welsh specific duties.

Internal guidance

1.14 Internally, most public bodies have produced guidance to support their EIA process. The format and detail of the guidance and quality vary across public bodies. Some provide step-by-step guidance which outlines the process and steps for completing an EIA. Some embed practical information and links within templates.

1.15 A few public bodies do not provide guidance on their individual processes. Some of these provide direct one-to-one support from an equality officer (or equivalent) to the individual completing the assessment. Others signpost staff to the external guidance on the Practice Hub.

Training

What we looked for

That training on conducting an EIA is available for staff involved in developing EIAs and those that use them for decision-making.

What we found

Most public bodies offer training to those involved with EIAs through a variety of media.

1.16 Around two-thirds (31 of 44) public bodies we spoke to provide formal training to officers who are likely to complete or have an interest in EIA. This training frequently extends to elected members, board members and decision-makers.

1.17 Methods of training vary. Some offer face-to-face delivery of training, with much of this via video calls since the start of the COVID-19 pandemic. Many public bodies include online modules and e-learning tools on equality, and EIAs as part of their general staff training. Those public bodies that do not offer formal training nevertheless provide one-to-one support to individuals conducting EIAs and upskill them through the process.

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Quality assurance

What we looked for

An approach to ensuring the quality of the EIA process.

What we found

Half of public bodies had an approach to quality assurance, which varied from a simple sign-off on individual EIAs to more comprehensive peer learning to support improvement of the whole EIA process.

1.18 Half (22) of the public bodies have a quality assurance process in place for their EIA. The approach varies greatly. For some, quality assurance is about the quality of individual EIAs. Some require an EIA to be signed off by a senior officer. In Cardiff and Vale University Health Board, the lead officer conducting the EIA will work with an equality officer and a representative from Public Health Wales to review and interrogate the content of the EIA during its development. Other public bodies have begun to take a 'peer review' approach to developing EIA with input from experts from across the organisation.

1.19 A small number of public bodies use quality assurance to test the quality of their overall approach. For example, the Arts Council of Wales conducts an annual sample review of EIAs and uses the findings to improve the process.

Assessing impacts

02

2.1 The Wales specific duties require listed public bodies to assess the likely impact of proposed policies and practices, or those under review, on their ability to comply with the PSED. In doing so, they must have regard to certain types of information that they hold and meet specific requirements to engage with people or organisations that represent people with one or more protected characteristics. EHRC guidance and the Practice Hub set out in detail the steps public bodies can take to fulfil these requirements.

Screening

What we looked for

A clear approach to determining if an equality impact assessment is required.

What we found

Just over half of public bodies have a process for screening although many have stopped using screening, some due to risk of confusion or 'gaming' by staff.

2.2 There are no statutory exemptions setting out policies and practices that do not need to be assessed. However, the EHRC guidance and the practice hub include a 'screening' process to determine which policies or practices should have a full EIA.

2.3 Just over half (24 of 44) of public bodies we spoke to said that they have a screening process. Screening is most often a document template which an officer developing or reviewing a process or policy uses to determine whether they anticipate any impact on protected groups. The approach ranges in practice from a separate short impact assessment to a set of screening questions at the beginning of the full assessment template which determine whether to proceed with the full EIA.

2.4 Where a body decides it does not need a full EIA, they will usually retain a copy of the screening tool as evidence that it has considered the PSED. Most public bodies with a screening process will document the decision not to go ahead with a full EIA in the supporting papers that go to the cabinet or board.

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2.5   Most often, the policy lead keeps the detailed record of screening. However, a few public bodies are trying to strengthen practice and ensure central records are maintained. For example, Cardiff Council has developed an online assessment tool to support policy leads through the process and encourage consideration of impact at the earliest stages of policy development. As well as sending advice and guidance to the officer completing the online assessment, the tool also sends a copy of the screening information to the equality officers.

2.6   The 20 public bodies who do not have a screening process had often consciously removed the screening step. Many said screening was an unnecessary step, as there are very few of their decisions that will not have potential to impact on the PSED. Some public bodies said that there was also scope for confusion, with lead officers completing a screening form, thinking it was an EIA. Others were concerned that some officers may 'game' the process: tailoring their responses to screening in a way designed to result in a decision that no further assessment was required.

2.7   Those public bodies that do not have a screening process usually provide additional guidance or a process chart, clarifying when to conduct a full EIA. All public bodies also offer the lead officer an opportunity to consult with an equality officer.

Timing

What we looked for

EIAs being started at an early stage to inform the development of a policy or decision.

What we found

All public bodies intend to carry out an EIA as early as possible, but many recognise this is often not the case in practice, and in some cases EIAs are very late in the policy development or decision-making process.

2.8   All 44 public bodies intend that EIAs should be started as early in the development or review of a policy as possible. But many public bodies acknowledged that this often does not happen in practice.

2.9   The timing of EIAs is affected by whether policy leads know that they are required to do an EIA and if resources – staff and time – are available at the appropriate point. Sometimes, if public bodies must make decisions very quickly, they either do not do an EIA or do them late in the decision-making process. This can be too late to consider changing a policy to lessen any possible negative impact or to build on positive impacts.

2.10 Decisions at the start of the COVID-19 pandemic were often made without an EIA. This reflected the urgency of decisions but meant that the impact on vulnerable people was not formally assessed. In August 2020, the Senedd's Equality, Local Government and Communities Committee[10] recommended that the Welsh Government should ensure that each major policy or legislative decision is accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since August 2020 has published dozens of impact assessments related to the COVID-19 pandemic on its website.

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10 Senedd Equality, Local Government and Communities Committee, Into sharp relief: inequality and the pandemic, August 2020.

2.11   In most public bodies, papers accompanying decisions that go to cabinets or boards contain a box or section that refers to consideration of the equality duties. This serves as a backstop to prevent public bodies from making decisions without any regard to the duties, even though this generally would be very late in the process.

Use of evidence

What we looked for

Use of a range of evidence to support the assessment, including the views of those likely to be impacted and data on lived experience.

What we found

Public bodies use a mix of evidence, although there are gaps in available data on some protected characteristics and the inclusion of the views and lived experiences of people with protected characteristics is patchy.

Quantitative data

2.12   EIAs need a sound evidence base to inform their conclusions. The depth and detail of the information base vary across organisations and by assessment The depth of information and analysis often depends on the scale of the decision and the availability of relevant and specific evidence.

2.13   All public bodies expect to include some quantitative data, such as demographic information or service level data. Around two-thirds (29 out of 44) of public bodies include at least some examples of internal information sources and point to publicly available data in their guidance and templates. Some go further. For example, Merthyr Tydfil County Borough Council includes in its guidance a detailed list of sources where policy leads can find relevant evidence, with embedded links to external data sources.

2.14   There are some significant data gaps in the data that is available to public bodies. Generally, there is little information available about some protected characteristics, particularly sexual orientation, gender reassignment, and pregnancy and maternity. Data that is available at a national level is sometimes not available at a health board, council, or ward level, which makes it difficult for public bodies to understand their local populations with protected characteristics.

Qualitative information

2.15   The inclusion of qualitative information based on the views and experiences of people with protected characteristics is also patchy. When introducing new policies or changing services public bodies often undertake a consultation exercise. In the examples we saw, these were often targeted to the public in general, and it was difficult to see if the public body had sought to engage specifically with people from protected groups.

2.16   Nonetheless, we did see examples of EIAs where evidence from engagement with groups was covered. For example, when Snowdonia National Park Authority undertook an EIA on its communication and engagement strategy, the assessment considered how the strategy could engage with people who speak languages other than English or Welsh. It also considered impacts on those who were digitally excluded, a group that is more likely to include older people and more women than men.

2.17   Some respondents to our general call for evidence said that drawing more on the views and experience of people with protected characteristics would improve the quality of EIAs. This includes engaging with individuals and grassroots organisations as well as national organisations representing protected groups. Some respondents said that public bodies should do more to publicise consultations by a range of means, including but not restricted to social media.

2.18   Some all-Wales third sector bodies responding to our call for evidence said that they were often asked to provide views for EIA and that some cannot respond to all the requests they receive. Sometimes they do not have information on local services and impacts.

2.19   A few public bodies are trying to draw on the lived experience of people with protected characteristics through different forms of consultation. Some use existing networks for staff with protected characteristics to understand different perspectives. Others, draw on existing relationships with third sector groups to understand the lived experience.

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Identifying and mitigating likely impacts

What we looked for

Clear identification of likely impacts, including positive impacts in promoting equality, as well as negative ones.

Some consideration of cumulative impacts arising from other decisions that impact the same group or groups and how different protected characteristics combine (intersectionality).

Clear recommendations for mitigating negative impacts that have been acted on before the decision is made.

What we found

While there are examples of public bodies identifying specific impacts, often EIAs describe impacts in very broad terms. Very few identify the cumulative impacts of multiple decisions on groups or consider how different protected characteristics intersect. Very few can show how recommendations for mitigating impacts are followed through.

Specific impacts

2.20 Positively, our review of EIAs found examples of public bodies clearly identifying specific likely impact of policies or practices on protected groups. However, many EIAs included statistics to describe the population of people with protected characteristics without being clear how the policy or practice would likely impact on them. We also observed a tendency for EIAs to focus on negative impacts, thereby missing positive impacts and opportunities to improve cohesion and reduce inequalities.

2.21 We found that most EIAs reviewed provided data and information on each protected group separately. For example, the EIA on Conwy County Borough Council's Older Peoples' Domiciliary Care Finance and Commissioning Project set out the likely impact on people with each protected characteristic.

2.22 Most public bodies' approaches to EIA involve making recommendations to overcome negative impacts. Public bodies should incorporate mitigating actions into the policy development process, recognising it is not always possible to mitigate all negative impacts, such as with reductions in service. Very few public bodies have a process in place to track whether they have implemented the mitigating actions, after a decision is taken. In Hywel Dda University Health Board, the EIA has an associated action plan with a review date. In Aneurin Bevan University Health Board the Equality, Diversity, and Inclusion specialist keeps a database of actions arising from EIAs for monitoring purposes.

Intersectionality

2.23 Increasingly, it is understood that inequality is intersectional. People's characteristics interact in a complex way to give a unique experience of inequality. For example, the experience of a Muslim woman cannot separate 'female' and her experience as a Muslim. It will differ from that of a Muslim man and of a non-Muslim woman. However, we did not see examples of such nuanced understandings of inequality in the examples we reviewed.

Cumulative impacts

2.24 Public bodies in Wales make many decisions each year that, taken together, can be very detrimental to people from protected groups. For example, one respondent to our call for evidence gave the example of how individual decisions to reduce or close facilities and services such as public toilets, library services, day centres, and bus services had a cumulative impact on many older people who use the services. They said that, while each individual decision might not be significant, together they meant that some older people were becoming isolated.

2.25 The few instances we found where public bodies have begun to give thought to cumulative impacts tend to be when public bodies are making several decisions at the same time. For example, councils usually undertake a cumulative approach to assessing the impacts of their proposed budget each year. Individual service changes being proposed because of budget changes are assessed simultaneously allowing a better overview of potential impacts for the budget.

2.26 Typically, however, public bodies make decisions separately. One of the
respondents to our call for evidence to decision-makers highlighted that it
is difficult in principle to predict the likely impacts of multiple decisions in a
complex landscape. Practically, the ability to take account of impacts from
other decisions relies on the policy lead knowing about other decisions
within an organisation and having access to the EIAs. A small number
of public bodies are trying to address this information gap by using an IT
solution to undertake the EIA (**paragraph 1.6**). This way, the assessment
of impact for each policy change and decision is held centrally, making it
easier for policy leads to bring together the information.

Decision-making

What we looked for

That the EIA and likely impacts it identifies are considered at the point of
decision-making.

What we found

Equality officers' views varied around the extent to which their
organisations prioritised the EIA in decision-making. Most respondents to
our general call for evidence said public bodies did not pay
sufficient regard to protected characteristics. The small number
ofresponses from decision-makers suggest a view that the EIA
is seen as a 'tick box exercise'.

2.27 The consideration given to EIAs in decision-making varies across public bodies in Wales. In general, equality officers felt that decision-makers take assurance in knowing that the policy lead has completed an EIA. Decision-makers will have access to a summary or the complete EIA accompanying each decision in their cabinet or board papers.

2.28 The equality officers we spoke to had mixed views over the extent to which their organisations placed sufficient weight on the EIA in decision-making. Over three-quarters of respondents to our general call for evidence who answered the question (29 of 37) disagreed that public bodies in Wales give appropriate due regard to people with protected characteristics when developing policies or making changes to services.

2.29 Generally, equality officers were not aware of instances where decision-makers challenged the content or recommendations of an EIA at the point of decision. Most felt that the accompanying EIA should have considered and shaped the policy sufficiently that there would be no need for such challenge at that late stage.

2.30 We only received ten responses to our call for evidence from decision-makers. While it is hard to draw conclusions from such a limited evidence base, it is notable that three of the ten referred to EIAs being used like a 'tick box'.

Powell,Bethan
09/11/2022 17:40:53

Reporting and monitoring impacts

03

3.1   Public bodies must publish reports of the assessments where they show a
      substantial impact (or likely impact) on their ability to meet the PSED. They
      must also monitor the actual impact of the policies and practices subject to
      an equality impact assessment.

Reporting

What we looked for

Public information about decisions and a clear description of how the EIA
has influenced the decision-making.

What we found

Most public bodies publish some of their EIAs as part of a wider
set of papers and they are often not easy to find.

3.2   Almost all public bodies in Wales publish their EIAs, at least in part.
      Typically, they publish EIAs with decision-related papers, such as cabinet
      or board papers. There is usually a section on the body's website which
      holds all the papers for each meeting and is accessible to the public[11].
      There are a few exceptions in some of the smaller public bodies, who do
      not routinely publish their EIAs.

3.3   It can often be difficult to find EIAs which relate to a specific decision on
      public bodies' websites. The EIAs which feature more prominently and are
      easier to locate often relate to strategic decisions such as budgets or key
      corporate strategies. Newport City Council have tried to bring EIAs into
      a central location on their website to make them more easily accessible,
      while recognising that this approach relies on the individuals completing
      EIAs sharing them for publication, which sometimes does not happen.

11 In some instances, bodies do not publish EIAs if they form part of a paper that is held
   back from publication due to its confidential or sensitive nature. However, these EIAs can
   sometimes be obtained via a Freedom of Information request if someone has a particular
   interest in seeing them.

Monitoring impacts

What we looked for

A clear approach to monitoring the impacts of the decision after it is implemented, including those identified as part of EIA as well as any unexpected impacts.

What we found

Very few public bodies monitor the impact of the decisions in the context of the PSED.

3.4 Some public bodies require those completing EIAs to identify a review date when monitoring is supposed to occur. We saw examples where EIAs set out plans for monitoring. For example, a Powys Teaching Health Board EIA included plans for monitoring service use after a change in surgery opening hours and for and independent evaluation of the service change. Also, Conwy County Borough Council's EIA for its review of domiciliary care included detailed arrangements for monitoring the impact using data and information that are routinely reported, including individual feedback from people receiving care.

3.5 However, equality officers had seen little evidence of the impact of policies and practices being monitored in light of the EIA. Those public bodies that outlined a monitoring process were often referring to the monitoring of an implementation of a policy or practice against its objectives or targets, not the impact that the decision had on people with protected characteristics.

3.6 In general, public bodies do not consider the impacts of policies and practices in terms of the PSED until there is another decision due on the same policy or practice. At that point, the body conducts a new EIA. Many of the equality officers we spoke to seemed unsure about how, in practice, they would monitor the impact of a decision on protected groups and would welcome more guidance.

Powell, Bethan
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Challenging EIAs

What we looked for

That the organisation identifies and applies lessons from any challenge to decisions on the basis of equality or the quality of the EIA.

What we found

Many equality officers did not think there had been any challenges to EIAs conducted by their organisation, but where there has been challenge some public bodies are using it as a learning opportunity.

3.7 Decisions made by public bodies can be challenged based on the EIA. Public bodies that do not have a clear record showing that they have considered the likely impacts of their decisions for people with protected characteristics leave themselves open to challenge. This could potentially include a judicial review. Some equality officers did not know what process someone would use to challenge an EIA. The majority said that any challenges would go through their general complaints process, with the involvement of the relevant service, equality officers and legal team.

3.8 Many equality officers thought there had not been any challenge to an EIA conducted by their organisation. Those that were aware of challenge taking place said that it was something that happens infrequently. Almost half of respondents to our general call for evidence who answered the question (17 of 35) said they had challenged some aspect of an EIA. We do not know if this was a formal or informal challenge.

3.9 Equality officers who had experienced challenge to an EIA said their organisation can resolve the issues either by making changes to a policy or practice, or by providing evidence that they had considered the impacts. Respondents to our general call for evidence gave examples of issues they raised being resolved. For example, one had objected to the EIA conducted on a new bus interchange because the council had not sought the views of people with protected characteristics on the proposals. Following their intervention, people with low vision visited the site and suggested changes to make the interchange more accessible.

3.10   While there are positive examples of public bodies responding to
       challenge, several respondents to our general call for evidence who had
       challenged aspects of an EIA reported not receiving any response to
       their challenge. A few equality officers told us that their organisation had
       learnt from the experience of having an EIA challenged. One had used
       examples of challenge from other public bodies to inform its EIA training as
       a particularly useful way of making impacts more easily understood to lead
       officers conducting EIAs.

Appendices

1   Audit approach and methods

1   Audit approach and methods

Audit approach

Our main aim was to provide insight about the approach to EIAs undertaken across the public sector in Wales. We wanted to highlight good practice and identify opportunities to improve. To help shape our thinking about what good practice to look for, we drew heavily on existing guidance materials, in particular that produced by the Equality and Human Rights Commission (EHRC) and the Equality Impact Assessment in Wales Practice Hub hosted by Public Health Wales NHS Trust.

We set out to explore to what extent public bodies have integrated their approach to undertaking EIAs, including the new socio-economic duty and the cumulative impact of decisions. We also explored what difficulties public bodies experience that affect the quality and timeliness of EIAs. We looked at how public bodies monitor the impact of decisions on their population. Each of the sub-sections in the main body of this report describes what we were looking for through our work.

In looking across the public bodies, we focused on the 44 public bodies originally subject to the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is the external auditor of each of these bodies, which include local authorities, health boards and some NHS trusts, national parks, and fire and rescue services. They also include the Welsh Government and some of its sponsored bodies. Our audit coverage did not include education bodies – further education, higher education or maintained schools – that are subject to the PSED. It also did not include the four Corporate Joint Committees (CJCs) established by the Local Government and Elections (Wales) Act 2021 and which are subject to the PSED.

Audit methods

Document review: We reviewed documents from each of the 44 public bodies, including those relating to the equality plans and details of the organisation's EIA process. We also reviewed details of their process for integrated impact assessments. We reviewed a sample of 29 EIAs provided by public bodies: 11 by local authorities, eight by health bodies, two fire and rescue, two national parks and six by the Welsh Government or its sponsored bodies.

Interviews: We interviewed the equality officers or their equivalent in each of the 44 bodies. We have used the term 'equality officer' throughout this report to refer to staff in public bodies with specific lead specialist roles for equality, whether that be their full-time job or part of their role. The way these roles are structured, and their seniority, varies.

Call for evidence: We sought wider views about people's experience of EIAs through a call for evidence between October 2021 and June 2022. We publicised this generally and in particular to third sector organisations. We received 40 responses, 23 from individuals and 15 responding on behalf of an organisation (two did not say).

We also sought the views of decision-makers through a separate call for evidence open between February and June 2022. We received ten responses (eight from individuals working in local authorities, one health and one fire and rescue).

While the responses we received to the calls for evidence are not necessarily representative of individuals, the third sector or decision-makers, they have provided useful detail which we have included through the report and which informed our overall analysis.

Stakeholder engagement: The EHRC is responsible for promoting and enforcing equality and non-discrimination laws. We met with officials in the EHRC Wales Team regularly throughout our work, discussing our scope and emerging findings. We also met with the Welsh Local Government Association's equality network and the Chair of the All-Wales NHS Equality Leadership Group. We interviewed officials from the Welsh Government with responsibility for equality policy.

Wider audit intelligence: We drew on existing intelligence from our local financial and performance audit work, where that was relevant to equality impact assessments.

Archwilio Cymru
Audit Wales

Audit Wales

24 Cathedral Road

Cardiff

CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

We welcome telephone calls in Welsh and English.

E-mail: info@audit.wales

Website: www.audit.wales

AUDIT, RISK AND ASSURANCE COMMITTEE	Date of Meeting: 15 November 2022
Subject:	**ANNUAL GOVERNANCE PROGRAMME Q2 UPDATE**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Board Secretary
Other Committees and meetings considered at:	Executive Committee, 9 November 2022

PURPOSE:
The purpose of this paper is to provide the Audit, Risk and Assurance Committee with the Q2 position regarding progress with the Annual Governance Programme.

RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee NOTES the position.

Approval/Ratification/Decision	Discussion	Information
✘	✔	✘

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	

Annual Governance Programme Reporting

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Audit, Risk and Assurance Committee
15 November 2022
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	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

The Annual Governance Programme is a comprehensive programme of improvement in the governance arrangements of the health board. Progress is reported regularly to the Executive Committee and to the Audit, Risk and Assurance Committee.

The latest update at Q2 shows the following progress made since the last report:

- development of induction for Independent Members;
- filling of all board vacancies;
- increased board development time focussed on key challenges at an early stage; and
- review and refresh of the risk management framework and risk appetite statement.

Limited progress has been made in formalising partnership governance arrangements which needs to be an area of focus going forward, linked to the Corporate Risk Register, together with development of the Board Assurance Framework.

Progress continues to be made in a number of other areas but they are not yet complete.

NEXT STEPS:

The Annual Governance Programme will continue to be reported regularly to the Executive Committee and Audit, Risk and Assurance Committee.

ANNUAL GOVERNANCE PROGRAMME

MILESTONES

2022/23

Quarter 2 Update

Annual Governance Programme

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Executive Committee
9 November 2022
Agenda Item:

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KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 / Q3 (21)	Q3 / Q4 (21)	Q4 / Q1 (22)	Q1 / Q2 (22)	
1. ENSURING CLARITY OF PURPOSE, ROLES, RESPONSIBILIIES AND SYSTEMS OF ACCOUNTABILITY							
a) Ensure that key supporting documents of the Board's governance framework continue to be fit for purpose at all levels, i.e. Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers	Adopt amendments to Standing Orders, as per nationally-led work	Director of Finance & IT (SFIs)	Green	Green	Green	Green	Action Complete – Approved by Board 28th July 2021.
	Review the Board's Scheme of Delegation and Reservation of Powers to ensure it reflects Executive Director portfolios and Board Committee arrangements for 2021/22		Amber	Amber	Green	Green	Scheme of Delegation and Reservation of Powers reviewed and revisions approved by Board May 2022.
	Board Scheme of Delegation and Reservation of Powers presented to Board for approval		Amber	Amber	Green	Green	
	Adopt revised Standing Financial Instructions as per nationally-led work		Green	Green	Green	Green	Action Complete – Approved by Board 28th July.
	Undertake an assessment of compliance with Standing Orders		Grey	Grey	Amber	Amber	Ongoing with reporting developments identified and implemented.
b) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of the	Organisational Structures to be confirmed via Organisational Realignment Working Group	All Executive Directors	Amber	Amber	Amber	Amber	Work remains underway to map organisational governance arrangements at a
	Levels of accountability, authority and autonomy to be confirmed and		Amber	Amber	Amber	Amber	

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KEY:			
Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
organisation, along with strengthened internal control	aligned to organisational policies and frameworks						Directorate/Team level to inform deployment and accountability arrangements.
	Directorate Deployment and Accountability Frameworks to be developed, aligned to the Board's Scheme of Delegation and Reservation of Powers						
c) Develop a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical	Identify all existing partnerships and collaborations to inform development of a Framework	Director of Planning & Performance					Overview of partnership governance arrangements presented to board at Strategic Planning Session and Planning, Partnerships & Population Health Committee.
	Mapping of these partnerships and collaborations against existing and proposed governance arrangements to ensure appropriate and robust information flows for monitoring and assurance purposes						
	Development and population of a Partnership Register						Due to capacity constraints, development of the Partnership Governance Framework has been delayed but is in the work programme for PPPH and Board.
	Development of the Partnership Governance Framework for presentation to Board in September 2022						

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Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
d) Further strengthen mechanisms for recording and reporting gifts, hospitality and sponsorship	Embed Standards of Behaviour Policy in a targeted phased approach, including communication, training and reporting to Audit, Risk & Assurance Committee	n/a	🟧	🟧	🟧	🟧	Discussions are taking place nationally with regard to the development of electronic recording of interests. Work is also underway to develop an all-Wales Policy.
	Fully implement an electronic system to support recording and reporting of declarations made		🟧	🟧	🟧	🟧	
2. ENSURING BOARD EFFECTIVENESS							
a) Review and strengthen the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure	Review committee structure for implementation in 2021/22	Chair/Committee Chairs	🟩	🟩	🟩	🟩	Action Complete – Approved by Board 28th July.
	Review committee terms of reference and operating arrangements with any changes presented to Board for approval in May 2021		🟩	🟩	🟩	🟩	Action Complete – Approved by Board 28th July.
	Review committee membership with any changes presented to Board for approval in May 2021		🟩	🟩	🟩	🟩	Action Complete – Approved by Board 28th July.
	Fully populate committee workplans, aligned to the Corporate Risk Register and Board Assurance Framework, for Board approval in May 2021		🟩	🟩	🟩	🟩	Action Complete – Approved by Board 29th September.
b) Fully establish the Board's Advisory Structure, i.e. the Healthcare Professionals'	Review Terms of Reference and membership of the Stakeholder Reference Group	• Director of Planning &	🟥	🟥	🟧	🟧	Research has been undertaken regarding the benefit to the

Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
Forum (HPF) and the Stakeholder Reference Group (SRG)	Meeting of the SRG to be held	• Performance (SRG) • Clinical Directors (HPF)	RED	RED	YELLOW	YELLOW	health board of these fora in addition to existing engagement arrangements. Paper to be produced outlining the approach to engagement to crystallise this research into a decision on whether these fora are to be implemented.
	Appoint Chair of the SRG as an Associate Member of the Board		RED	RED	YELLOW	YELLOW	
	Review current engagement mechanisms with professionals to inform approach to HPF		RED	RED	YELLOW	YELLOW	
	Terms of Reference and Membership of HPF to be developed		RED	RED	YELLOW	YELLOW	
	Inaugural meeting of HPF to be held		RED	RED	YELLOW	YELLOW	
	Appoint Chair of the HPF as an Associate Member of the Board		RED	RED	YELLOW	YELLOW	
c) Ensure openness and transparency in the conduct of board and committee business	Review effectiveness of live streaming board meetings	Chair	YELLOW	YELLOW	YELLOW	YELLOW	Live streaming of board meetings continues. Arrangements for members of the public to observe committees in place, in the absence of live streaming. Papers published to website as routine.
	Consider accessibility of those committee meetings required to be held in public		YELLOW	YELLOW	YELLOW	YELLOW	
	Ensure meeting agendas, papers and summary notes are published in a timely manner		YELLOW	YELLOW	YELLOW	YELLOW	
d) Further improve the quality of information to	Board & Committee report templates to be reviewed to ensure assurance	Director of Workforce & OD	RED	RED	YELLOW	YELLOW	Report templates are in development.

Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
the Board and its Committees	reports are distinguished from reports for management		🟥	🟥	🟨	🟨	
	Report Writing and Presentation Masterclasses to be held for senior management team, via the Management Development Programme		🟥	🟥	🟥	🟥	Due to capacity constraints, this work has been delayed.
e) Implement an annual development programme for board members, focussing on awareness sessions as well as training and learning to support the development of individual roles and the board as a cohesive team	Board review of effectiveness to be undertaken in April 2022	• Chair • Director of Workforce & OD	🟩	🟩	🟩	🟩	Board review of effectiveness undertaken in Board Development session undertaken in April 2022.
	Implement a programme of development and a programme of briefings for 2022/23		🟨	🟨	🟨	🟩	A list of potential sessions is maintained by the Corporate Governance Team. Board Development and Briefing Sessions are being delivered on a regular basis to the areas of greatest need which are currently finance and service development.

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Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
	Ongoing implementation of an Executive Director Development Programme		🟧	🟧	🟧	🟧	Programme of development ongoing.
	Design and implement training and development for Independent Members		🟧	🟧	🟧	🟧	IM specific training to be developed to supplement development of the programme of induction. IM induction pack developed and implemented.
f) Ensure a programme of comprehensive recruitment and induction for Independent Board Member appointments, where required	Work with Public Bodies Unit to prepare and deliver recruitment campaigns for upcoming vacancies	Director of Workforce & OD	🟧	🟧	🟧	🟩	IM LA has been appointed to which is the last remaining vacancy on the Board.
	Implement an Induction Programme for Board Member appointments when required		🟧	🟧	🟧	🟩	WG Induction Programme in place. Local Induction arrangements have been developed including a Board Member library of key documents and policies and an induction pack.

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KEY:			
Action Complete	**Action Underway**	**Action Not Yet Started**	**Action Not Due in this Quarter**

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
g) Develop and implement a programme of board member visits around the County to promote visibility, openness and engagement	Design and implement a schedule of visits to a range of clinical and non-clinical services and county-wide health board sites	• Chair • Chief Executive	Amber	Amber	Amber	Amber	Some CEO/Executive Director visits re-commencing. Programme of visits for the new health board Chair being developed.
h) Review and implement arrangements for the development, review, approval and publication of policies delegated by the Board	Policy Management Framework to be reviewed, confirming policy approval routes	Executive Director Policy Owners	Red	Amber	Amber	Amber	Work is progressing but is not yet complete linked to the introduction of Sharepoint. Policy Management Framework review nearing completion.
	Policies section of intranet/internet to be refreshed		Red	Amber	Amber	Amber	
	Policy toolkit to be rolled out with awareness raising		Red	Amber	Amber	Amber	
	Training programme to be developed and implemented to support the organisation in developing and reviewing policies		Red	Amber	Amber	Amber	
i) Review Board Champion Roles, ensuring clarity on purpose and responsibility.	Review delegation of Champion roles to Board Members	Chair	Amber	Amber	Green	Green	Board Champion roles clarified at March board meeting. Reporting arrangements to be established.
	Adopt role specifications for Champion roles		Amber	Amber	Amber	Amber	
	Establish reporting arrangements for Champions to Board		Amber	Amber	Amber	Amber	
3. EMBEDDING AN EFFECTIVE SYSTEM OF RISK AND ASSURANCE							

KEY:			
Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
a) Ensure that the Risk Management Framework continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner	Undertake an Annual Review of Risk Management Framework, ensuring alignment with the Board's Assurance Framework Principles	n/a					A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2022.
	Risk Management Framework to be updated to reflect Risk Appetite Statement						
	Establish Committee Risk Registers						Committee priorities informed by strategic risks (corporate risk register). Further work required to refine operational risk registers to inform committee risk registers.
b) Promote a Risk Management Toolkit to support staff in the identification, recording and management of risk	Publish a Toolkit including the process for escalation and de-escalation, examples of best practice to support moderation and consistency in measurement	n/a					A Risk Management Toolkit has been developed and published to the Health Board's Intranet and will also be promoted through the Risk & Assurance Group, constituted by
	Toolkit to be updated in line with review of Risk Management Framework, Risk Appetite Statement						

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KEY:			
Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
	and Board Assurance Framework Principles.			(green)			key leaders within the organisation. Periodic recommunication will be undertaken as highlighted by the recent internal audit review.
c) Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks	Risk Appetite Statement to be considered by Board in June 2021	n/a	(green)				A reviewed and refreshed Management Framework and Risk Appetite Statement has been prepared for presentation to Board in November 2022.
	Revised Statement to be presented to Board in July 2021 for approval		(green)				
	Corporate Risk Register, Risk Targets to be reviewed to ensure alignment with the Board's Risk Appetite		(amber)	(amber)	(amber)	(green)	Revised Corporate Risk Register reported to Board September 2022.
	Risk Management Framework to be updated to reflect Risk Appetite Statement and communicated with the organisation		(green)				A reviewed and refreshed Management Framework and Risk

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KEY:

Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
				Green (spanning)			Appetite Statement has been prepared for presentation to Board in November 2022.
d) Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints System [DATIX])	Risk Management Module to be developed in-line with Once for Wales Management System Programme, in readiness for implementation in 2022	n/a	Amber	Amber	Grey	Grey	Once for Wales Management System implementation underway, aligned to national work. Risk & Assurance Group continues to meet where possible to maintain focus on operational risk management.
	Maximise the role of the Risk and Assurance Group to drive forward improvements in risk reporting arrangements		Amber	Amber	Grey	Grey	
e) Embed the Board's Assurance Framework, aligned to the Corporate Risk Register and Organisational Risk, where appropriate	Undertake an Annual Review of Assurance Framework Principles, ensuring alignment with the Board's Risk Management Framework	n/a	Red	Red	Amber	Amber	The Board Assurance Framework is in the process of being reviewed. The Board continues to receive its Corporate Risk Register at each meeting and Board/Committee priorities have been
	Board and committee workplans aligned to Assurance Framework		Amber	Amber	Amber	Amber	
	Assurance Framework updated quarterly, in-line with integrated performance reporting and delivery of audit programmes		Red	Red	Amber	Amber	

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Action Complete	Action Underway	Action Not Yet Started	Action Not Due in this Quarter

Objective	Planned Deliverables	Board Secretary to Lead with	RAG Status				Comments
			Q2 Q3 (21)	Q3 Q4 (21)	Q4 Q1 (22)	Q1 Q2 (22)	
							determined based on risk.
f) Introduce a system of Organisational Assurance Mapping at a directorate and functional level to inform internal control arrangements.	Establish Assurance Maps to identify assurances in place and any gaps in place at 1st, 2nd and 3rd line of defence for those responsibilities delegated to Executive Directors	All Executive Directors					This work has been delayed in light of the pandemic. However, work in relation to delegation and accountability arrangements continues (as per action 1b).
	Gaps in assurance to inform the Board's Assurance Framework						

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Audit, Risk and Assurance Committee	DATE OF MEETING: 15 November 2022
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 9 November 2022

PURPOSE:

The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the position relating to the implementation of Audit Recommendations, arising from reviews undertaken by Internal Audit, External Audit (Audit Wales) and Local Counter Fraud Services as of 30 September 2022.

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to NOTE and DISCUSS the current position of outstanding Audit Recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

Strategic Objectives:	1. Provide Early Help and Support	
	2. Tackle the Big Four	
	3. Enable Joined up Care	

Implementation of Audit Recommendations

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Audit, Risk and Assurance Committee
15 November 2022
Agenda Item: 3.6

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	4. Develop Workforce Futures	
	5. Promote Innovative Environments	
	6. Put Digital First	
	7. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

BACKGROUND AND ASSESSMENT:

INTERNAL AUDIT

During September 2022, an exercise was undertaken to review the revised deadlines implemented as a result of the COVID-19 priority level. Executive Owners were provided an opportunity to review any outstanding recommendations from 2017/18, and 2019/20 and re-consider where appropriate, achievable final deadlines for implementation that could be monitored against. The revised deadlines are included within the appendices. All recommendations from 2018/19 are now complete.

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

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

Covid-19 Prioritisation	2017/18	2018/19	2019/20	Internal Audit Priority	2020/21	2021/22	2022/23	TOTAL OUTSTANDING
	Number				Number			Number
Priority 1	0	0	0	High	2	7	0	9
Priority 2	5	0	6	Medium	4	9	0	24
Priority 3	0	0	5	Low	1	3	0	9
Not Yet Prioritised	0	0	0					0
TOTAL	5	0	11		7	19	0	42

Detail of re-prioritised internal audit recommendations can be found appended to this report as follows: -
Appendix D – Internal Audit Recommendations that remain OUTSTANDING
Appendix E – Internal Audit Recommendations COMPLETED since the previous report
Appendix F –Internal Audit Recommendations NOT YET DUE for implementation

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EXTERNAL AUDIT

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

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

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix G – External Audit Recommendations that remain OUTSTANDING.

Since the previous report to the Committee, there have been no External Audit Recommendations COMPLETED and none are NOT YET DUE for implementation.

LOCAL COUNTER FRAUD SERVICES

There are currently no outstanding recommendations from Local Counter Fraud Services Pro-Active Exercises.

NEXT STEPS:

Progress against outstanding audit recommendations will continue to be monitored by the Executive Committee and Audit, Risk and Assurance Committee.

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2017/18 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
171801	Commissioning - Embedding the Commissioning Assurance Framework	Reasonable	0	2	1	0	2	1							✓
171802	Clinical Audit Programme Follow-Up	Limited	1	2	2	1	2	2							✓
171803	Estates Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
171804	Safe Water Management (including Legionella)	Limited	1	6	0	1	6	0							✓
171806	Risk Management	Limited	2	1	0	2	1	0							✓
171807	Procurement of Consultant and Agency Staff	Limited	5	1	0	5	1	0							✓
171808	Engagement with Primary Care Providers	Limited	1	4	0	1	4	0							✓
171809	Public Health - Influenza Immunisations	Reasonable	1	2	0	1	2	0							✓
171810	Public Health - Smoking Cessation for Pregnant Women	Reasonable	0	3	1	0	3	1							✓
171811	Information Commissioner's Office Recommendations Report Follow-Up	Reasonable	2	4	1	2	4	1							✓
171812	Medicines Management – Patient Group Directions (PGDs)	Limited	7	1	0	7	1	0							✓
171813	Llandrindod Wells Redevelopment	Reasonable	0	11	1	0	11	1							✓
171814	Workforce Planning	Reasonable	1	1	0	1	1	0							✓
171815	Review of the Health and Care Strategy – Programme Management	Reasonable	1	3	1	1	3	1							✓
171816	Integrated Medium Term Plan – Monitoring and Reporting of Performance	Reasonable	0	1	3	0	1	3							✓
171817	Policies Management	Reasonable	0	4	1	0	0	1	0	4	1	0	5	0	✗
171818	Information Governance General Data Protection Regulation (GDPR)	Reasonable	0	3	3	0	3	3							✓
171819	Electronic Staff Record System	Reasonable	0	3	1	0	3	1							✓
171820	Banking & Cash Management	Reasonable	0	1	4	0	1	4							✓
171821	Budgetary Control and Financial Savings	Reasonable	1	2	2	1	2	2							✓
171822	Disaster Recovery Arrangements	Reasonable	0	2	3	0	2	3							✓
171823	Financial Planning	Reasonable	0	3	1	0	3	1							✓
171824	General Ledger	Substantial	0	0	1	0	0	1							✓
171825	IT Governance and Resilience Follow-Up	Reasonable	0	2	1	0	2	1							✓
171826	Localities Operational Management follow-up (Incorporating Patients' Property & Money Follow-Up and Declarations of Interest)	Limited	2	7	1	2	7	1							✓
171827	Medicines Management – Prescribing of Branded Generic Drugs	Reasonable	1	2	1	1	2	1							✓
171828	Personal Appraisal Development Reviews (PADRs)	Reasonable	1	1	0	1	1	0							✓
171829	Records Management Follow-Up	Reasonable	1	4	2	1	4	2							✓
TOTAL			**28**	**81**	**32**	**28**	**77**	**32**	**0**	**4**	**1**	**0**	**5**	**0**	

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2018/19 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	
181901	IMTP – Joint Planning Framework	Reasonable	0	1	1	0	1	1							✓
181902	Dental Services: Monitoring of the General Dental Services Contract	Limited	2	2	0	2	2	0							✓
181903	ICT Infrastructure	Reasonable	0	1	2	0	1	2							✓
181904	Podiatry Service	No Assurance	7	1	3	7	1	3							✓
181905	Recruitment and Retention	Reasonable	1	2	0	1	2	0							✓
181906	Environmental Sustainability Reporting	Reasonable	0	1	0	0	1	0							✓
181907	Commissioning – Primary Care (Advisory)	Not Rated	2	2	0	2	2	0							✓
181908	Asbestos Management	Reasonable	0	4	4	0	4	4							✓
181909	Occupational Therapy Service	Reasonable	0	6	0	0	6	0							✓
181910	Health and Safety	Limited	1	6	1	1	6	1							✓
181911	Section 33 - Governance Arrangements	Limited	2	1	1	2	1	1							✓
181912	Annual Quality Statement	Substantial	0	1	0	0	1	0							✓
181913	Departmental Review - Catering	Limited	3	3	1	3	3	1							✓
181914	Capital Systems	Reasonable	0	6	1	0	6	1							✓
181915	Temporary Staffing Unit	Reasonable	0	4	1	0	4	1							✓
181916	Cyber-Security Follow-up of Stratia Report	Reasonable	0	2	2	0	2	2							✓
181917	Putting Things Right – Lessons Learned (Midwifery)	Reasonable	0	1	3	0	1	3							✓
181918	Single Tender Waivers	Reasonable	0	3	0	0	3	0							✓
181919	Business Continuity Planning	Reasonable	1	2	2	1	2	2							✓
181920	Information Governance: General Data Protection Regulation (GDPR) - Compliance	Reasonable	0	1	2	0	1	2							✓
181921	Risk Management	Limited	2	1	0	2	1	0							✓
181922	Procurement of Consultant and Agency Staff Follow Up	Reasonable	0	3	1	0	3	1							✓
181923	Medicines Management (Patient Group Directions) Follow-Up Review	Limited	3	3	0	3	3	0							✓
181924	Estates Assurance Follow Up	Reasonable	0	6	4	0	6	4							✓
181925	Capital Assurance Follow Up	Reasonable	0	5	1	0	5	1							✓
181926	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1							✓
181927	Engagement with Primary Care Providers Follow-up	Limited	1	2	1	1	2	1							✓
TOTAL			**25**	**70**	**32**	**25**	**70**	**32**							

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2019/20 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Re-prioritised				All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	1	2	3	Not Yet Prioritised	
192001	Deprivation of Liberty Safeguards	Limited	2	1	0	2	1	0								✓
192002	Environmental Sustainability Reporting	Not Rated	0	2	1	0	2	1								✓
192003	Assurance on Implementation of Audit Recommendations	Reasonable	1	1	0	1	1	0								✓
192004	Financial Planning and Budgetary Control - Commissioning	Reasonable	0	2	3	0	2	3								✓
192005	Disciplinary Processes – Case Management	Reasonable	0	2	3	0	2	3								✓
192006	Records Management	No Assurance	6	0	0	4	0	0	2	0	0	0	2	0	0	✗
192007	Freedom of Information (FoI)	Limited	1	2	3	1	2	3								✓
192008	Staff Wellbeing (Stress Management)	Reasonable	0	3	0	0	3	0								✓
192009	Safeguarding – Employment Arrangements and Allegations	Reasonable	0	4	2	0	4	2								✓
192010	111 Service	Reasonable	2	3	0	2	3	0								✓
192011	Catering Services Follow-up	Reasonable	0	3	2	0	3	2								✓
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	2	3	1	1	3	1	1	0	0	0	0	1	0	✗
192013	Podiatry Service Follow-up	Limited	1	5	4	1	5	4								✓
192014	Care Homes Governance	Limited	1	2	3	0	0	3	1	2	0	0	3	0	0	✗
192015	Primary Care Clusters	Reasonable	1	3	1	1	3	1								✓
192016	Organisational Development Strategic Framework	Reasonable	0	2	0	0	1	0	0	1	0	0	0	1	0	✓
192017	Dental Services: Monitoring of the GDS Contract Follow-up	Reasonable	0	0	2	0	0	2								✓
192018	IT Service Management	Reasonable	0	2	1	0	2	1								✓
192019	Machynlleth Hospital Primary & Community Care Project	Reasonable	1	4	1	1	4	1								✓
192020	Welsh Risk Pool Claims Management	Substantial	0	0	1	0	0	1								✓
192021	Capital Assurance Follow Up	Substantial	0	1	0	0	1	0								✓
192022	Outpatients Planned Activity	Reasonable	1	3	0	1	2	0	0	1	0	0	0	1	0	✗
192023	Estates Assurance Follow Up	Reasonable	0	1	2	0	1	1	0	0	1	0	0	1	0	✗
192024	Financial Safeguarding (Estates)	Reasonable	0	5	1	0	5	1								✓
192025	Financial Safeguarding (Support Services)	Reasonable	0	3	0	0	3	0								✓
192026	Risk Management and Board Assurance	Limited	2	3	0	2	2	0	0	1	0	0	1	0	0	✗
192027	Welsh Language Standards Implementation	Limited	2	1	0	2	0	0	0	1	0	0	0	1	0	✗
192028	Section 33 Governance Arrangements Follow Up	Reasonable	0	2	1	0	2	1								✓
	TOTAL		**23**	**63**	**32**	**19**	**57**	**31**	**4**	**6**	**1**	**0**	**6**	**5**	**0**	

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2020/21 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	
202101	Environmental Sustainability Reporting	Not Rated	0	1	0	0	1	0				✓
202102	Estates Assurance – Fire Safety	Limited	2	5	0	2	5	0				✓
202103	Health and Safety Follow-up	Reasonable	0	3	2	0	3	2				✓
202104	Annual Quality Statement	Not Rated	0	1	0	0	1	0				✓
202105	Advanced Practice Framework	Not Rated										✓
202106	Capital Systems	Substantial	0	0	4	0	0	4				✓
202107	GP Access Standards	Substantial	0	0	1	0	0	1				✓
202108	Partnership Governance – Programmes Interface	Limited	3	1	1	1	1	1	2	0	0	✗
202109	IM&T Control and Risk Assessment	Not Rated	0	0	14	0	0	14				✓
202110	Freedom of Information Follow Up	Substantial										✓
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	0	2	0	0	0	0	0	2	0	✗
202112	Grievance Process	Reasonable	0	1	0	0	1	0				✓
202113	Safeguarding during COVID-19	Reasonable	0	1	1	0	1	1				✓
202114	Implementation of digital solutions	Reasonable	0	3	0	0	3	0				✓
202115	Winter pressures and flow management	Reasonable	0	3	1	0	1	0	0	2	1	✗
202116	Llandrindod Wells Project	Limited	0	5	1	0	5	1				✓
202117	Covid-19 Mass Vaccination Programme	Not Rated										✓
	TOTAL		**5**	**26**	**25**	**3**	**22**	**24**	**2**	**4**	**1**	

2021/22 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made			Audit Recs Implemented			Audit Recs Overdue (agreed timescale)			Audit Recs Not Yet Due			All Audit Recs Implemented
			H	M	L	H	M	L	H	M	L	H	M	L	
212201	Access to Systems	Reasonable	1	1	1	1	1	1							✓
212202	Control of Contractors	Limited	4	2	1	4	2	1							✓
212203	Medical Equipment and Devices	Reasonable	3	3	1	0	0	0	1	3	1	2	0	0	✗
212204	Midwifery – Safeguarding Supervision	Reasonable	0	2	0	0	1	0	0	1	0	0	0	0	✗
212205	COVID Recovery and Rehabilitation Service	Substantial	0	1	0	0	1	0							✓
212206	Theatres Utilisation	Reasonable	2	2	1	0	0	0	2	1	1	0	1	0	✗
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	1	1	1	3	0	0	0	0	✗
212208	Waste Management	Reasonable	0	5	0	0	4	0	0	1	0	0	0	0	✗
212209	Job Matching and Evaluation Process	Reasonable	0	2	1	0	2	1	0	0	0	0	0	0	✓
212210	Mortality Review	Reasonable	0	5	1	0	5	0	0	0	0	0	0	1	✗
212211	Machynlleth Hospital Reconfiguration Project	Reasonable	1	5	1	1	5	1							✓
212212	Network and Information Systems (NIS) Directive	Reasonable	0	3	1	0	3	1	0	0	0	0	0	0	✓
212213	Budgetary Control	Substantial	0	1	0	0	1	0	0	0	0	0	0	0	✓
212214	Occupational Health Service	Limited	1	0	0	0	0	0	3	0	0	0	0	0	✓
212218	Recommendation Tracking Process & Follow Up Review	Substantial	0	0	2	0	0	1	0	0	1	0	0	0	✓
TOTAL			**13**	**36**	**11**	**6**	**26**	**7**	**7**	**9**	**3**	**2**	**1**	**1**	

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2022/2023 Internal Audits

Ref	Audit Title	Assurance Rating	Audit Recs Made				Audit Recs Implemented				Audit Recs Overdue (agreed timescale)				Audit Recs Not Yet Due				All Audit Recs Implemented
			H	M	L		H	M	L		H	M	L		H	M	L		
222301	IT Infrastructure and Asset Management	Limited	4	3	0		0	0	0		0	0	0		4	3	0		✗
	TOTAL		**4**	**3**	**0**		**0**	**0**	**0**		**0**	**0**	**0**		**4**	**3**	**0**		

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2018/19 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			All Audit Recs Implemented
					1	**2**	**3**	
181951	Structured Assessment 2018	12	9	3	0	2	1	�x
181952	Clinical coding follow-up review	4	4					✓
181953	Audit of Financial Statements Report	4	4					✓
	TOTAL	**20**	**17**	**3**	**0**	**2**	**1**	

2019/20 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised			All Audit Recs Implemented
					1	**2**	**3**	
192051	Structured Assessment 2019	3	3					✓
	TOTAL	**3**	**3**	**0**	**0**	**0**	**0**	

2020/21 External Audits

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	**2**	**3**	Not Yet Prioritised		
202151	Effectiveness of Counter-Fraud Arrangements	3	3							✓
202152	Structured Assessment 2020	11	9	2	0	1	0	1	0	�x
202153	Audit of Accounts	6	6							✓
	TOTAL	**20**	**18**	**2**	**0**	**1**	**0**	**1**	**0**	

2021/22 External Audits

	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Revised Re-prioritised				Audit Recs Not Yet Due	All Audit Recs Implemented
					1	**2**	**3**	Not Yet Prioritised		
212251	Structured Assessment 2021 (Phase One)	0								✓
212252	Structured Assessment 2021	3	1	2	0	2	0	0	0	�x

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212253	Audit of Accounts Report - Charitable Funds and Other Related Charities	3	2	1	0	0	0	0	0	✗
	TOTAL	**6**	**3**	**3**	**0**	**2**	**0**	**0**	**0**	

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APPENDIX C

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Local Counter Fraud Services Pro-Active Exercises

Ref	Audit Title	Audit Recs Made	Audit Recs Implemented	Audit Recs Overdue (agreed timescale)	Audit Recs Not Yet Due	All Audit Recs implemented
202181	Pre-Employment Checks	3	3			✓
212281	Overpayments	3	3	0	0	✓
	TOTAL	**6**	**6**	**0**	**0**	

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PTHB Ref No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised	Reporting Date	Date Added to Tracker
171817	Policies Management	Reasonable	Board Secretary		R1	The Consultation Feedback Record should be completed each time a policy is created or reviewed and submitted to the Corporate Governance Department. The record should clearly document what engagement and consultation has taken place and how feedback received has been incorporated into the policy. The recommended consultation period of a minimum of 14 days should be applied to ensure that consultation with relevant stakeholder groups has been conducted thoroughly and that comments have been incorporated into the policy.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents.	May-18	Mar-23	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Sep-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R2	All policies should be forwarded to the Corporate Governance Department so that a quality review can be carried out and confirmation given of the appropriate approval route. All policies should be accompanied by the submission approval form confirming that spelling, grammar and content checks have been carried out.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. As set out in recommendation 4 below, the ability to upload polices onto the intranet will be restricted to members of the Corporate Governance Department.	May-18	Mar-23	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Sep-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R3	In accordance with the procedure the submission and approval form should be completed for all documents, both reviewed / updated and new, and forwarded with the policy to the Corporate Governance Department.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed and the above requirements will be fully reflected and reinforced in the revised documents. Going forward policies submitted to the Corporate Governance Department without the submission and approval form will be returned to the relevant Executive Director.	May-18	Mar-23	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Sep-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R4	Policies should be issued within 5 days of being approved in line with Policy and a record of the date that policies are placed on the intranet should be retained. The ability to upload polices onto the intranet should be restricted to members of the Corporate Governance Department. The Policy and Procedures Index should be published on the intranet at regular intervals and consideration given to widening the scope of this document to include polices which are due for review.	Steps have been taken to address points 4a and 4c. The Policy and Procedures Index has been published and awareness raised through a Powys Announcement. Access rights to upload policies on to the Intranet (point 4b) are being reviewed and will be updated by the end of April 2018.	Apr-18	Mar-23	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme and is being picked up at greater pace by the corporate goverance team and clinical policies with clinical directors.	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		47	#NUM!	Sep-22	Feb-19
171817	Policies Management	Reasonable	Board Secretary		R5	Findings from this report should be considered and incorporated as appropriate before the policy is finalised. Where processes are no longer required or have been replaced these should be removed.	The Policy for the Management of Policies, Procedures and other Written Control Documents is currently being reviewed, the requirements set out in this report will be fully reflected in the revised documents.	May-18	Mar-23	Deadline Revised	2	Partially complete		Review and implementation of arrangements for the development, review, approval and publication of policies delegated by the Board has been built into the Annual Governance Programme	Competing priorities in the corporate governance team and organisational capacity to review policies.	Support on policy development is being provided to the organisation as and when required	Sep-22		46	#NUM!	Sep-22	Feb-19
192006	Records Management	No Assurance	Director of Finance, Information and IT		R4	The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained and that the points raised in this report are addressed, where weaknesses are identified.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Dec-22	Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the RM Improvement Plan. Detailed actions and lead officers have been identified. Options for on and off-site storage continue to be explored. Process has been implemented through the Property and Accommodation Group that all service requests to store records go via this group for approval. This process ensures the nebecessary risk assessments are undertaken with record to health & safety, security etc. This will also be further progressed through the Digitisation of records project due to commence Autumn 2022 A document and Records Manager has been appointed as a permanent role within the Information Governance Team (commenced February 2022) A digital project manager has been appointed due to start July 2022. Their role will be to project manage the digitisation of records Consultancy was procured to provide a strategic business case overview of current and future recommendates in relation to health records. A business case for the digitisation of records is due to be presented to IBG in August 2022 for funding approval. With a paper going to our Executive Committee thereafter Information Sharing Protocols will be reviewed/developed as part of the Cross Border Project	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed request extension to 31/12/22		25	#NUM!	Sep-22	14/11/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Dec-22	Deadline Revised	2	Partially complete		A Service Improvement Manager has been appointed from 1 February 2020 to address the requirements of the Records Management Improvement Plan. Detailed actions and lead officers have been identified. Process has been implemented through the Property and Accommodation Group that all service requests to store records go via this group for approval. This process ensures the necessary risk assessments are undertaken with record to health & safety, security etc. This will also be further progressed through the Digitisation of records project due to commence Autumn 2022	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed Request this is closed as actions will be captured now via the PM and Records Manager project plan and SIP and covered in the action line above		25	#NUM!	Sep-22	14/11/2019
192012	Hosted Functions – Governance Arrangements (Advisory)	Not Rated	Board Secretary	Board Secretary	R2	(a) That the health board obtains a copy of the original Hosting Agreement for CHC and continues to work with Welsh Government and the CHC to agree an accountability framework for the current arrangement. (b) The health board clarifies the accountability framework and governance systems for HRCW. (c) The health board ensures that the Welsh Government Hosting Agreements, and any signed replacement agreements, for the hosted functions are shared with all those health board staff managing and monitoring services provided to these hosted functions.	(a), (b) and (c) Discussions continue with Welsh Government regarding the ongoing development of a Hosting Agreement for CHC. The timeline for this work will be dependent upon tripartite agreement. Once complete, this work will be used to inform arrangements for other hosted arrangements, including HCRW.	Apr-20	Mar-23	Deadline Revised	3	Partially complete		Initial discussions have taken place with Welsh Government and CHCs with a view to develop a finalised hosting agreement which was complete; however this work was then superseded by the intended transfer to the Citizens Voice Body in 2022. Renewed discussions are taking place in line with organisational governance to review the current position in relation to Health Care Research Wales and a draft hosting agreement is being discussed with advice from NWSSP Legal and Risk Services. Both aspects will be overseen by the Audit, Risk and Assurance Committee.	Obtaining tri-partite agreement	CHC - Interim Board Secretary supporting the governance workstream of the CVB. HCRW - Quarterly meetings have been put in place between Director of W&OD, Interim Board Secretary and HCRW, with focussed hosting agreement review being undertaken with advice from L&RS.	CVB by 1 April 2023, HCRW uncertain due to tri-partite nature of any agreements.		29	#NUM!	Sep-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance / Director of Finance and IT & Director of Primary, Community and Mental Health Services / Director of Nursing	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC. 2.3 The CHC Standard Operating Procedures should be aligned with the Scheme of Delegation (Section 12) and practices in Adult and MH&LD CHC should be aligned. The CHC SOP should also be updated to clarify when contract renewals valued over £50,000 p.a. should go through a High Cost Resource Panel. 2.4 The health board should ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for CHC packages across Adult and Mental Health Nursing.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned to be 3-6 months long and commenced in early November 2019. Once the recommendations and/or revised Scheme of Delegation is issued the health board will undertake a review focusing on the recommendations of this report 2.3 CHC Standard Operating Procedure to be updated to ensure the all cases over £50,000 are referred to High Cost Panel 2.4 Formal communication to be issued from the Director of Finance to services leads for CHC (Adult and Mental Health) on the need to ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for all CHC packages. Additionally, to offer support if clarity is required on the Scheme of Delegation or SOP.	Dec-20	Sep-21	Over due	2	Partially complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of contracts, Standard Operating Procedures and Scheme of Delegation. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 Complex Care Project has commenced with Secondment to lead the work and review the requirements in line with the New Framework which is being implemented. Scheme of delegation and sign off procedures are in place and effective. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly.	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as part of the D2RA pathway implementation	Sep-21		21	12	Sep-22	

Ref	Title	Assurance	Responsible Officer	Lead	Rec	Recommendation	Management Response	Original Date	Revised Date	Status	Priority	Progress	Update	Risk	Action/Mitigation	Revised Date			Reported	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring. 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review form. The arrangements should mirror the joint monitoring process and include proactive consideration of recent inspectorate visits and feedback from the relevant local authority. 3.2 This process should be documented in the CHC SOP (see finding 4 also). In-county care homes monitoring 3.3 The health board should clarify how it receives assurance that the LA has escalated issues identified through the joint monitoring process to the JQAP as appropriate, for example through its representation at the JIMP and JQAP meetings and through feedback to the CCSG. 3.4 The health board's CHC SOP should be updated to make reference to the joint monitoring process under the S33 agreement, including the assurance it receives as per 3.3 (see finding 4 also). 3.5 The above recommendations on in- and out-of-county care homes monitoring should take into consideration the NHS Wales National Collaborative Commissioning Unit project on provider care map dashboards. 3.6 The assurance mechanisms over CHC and FNC packages, including for monitoring both in- and out-of-county care homes, should be incorporated into the Board Assurance Framework. Funded Nursing Care 3.7 The health board should be clear on how it receives assurance over the timeliness and accuracy of the FNC payments to the care homes. This should be documented in the SOP. 3.8 Management should ensure that issues relating to the care homes S33 agreement, including FNC, are escalated to an appropriate level, both with the Local Authority and within the health board. The LA should be reminded that health board approval is obtained on care requirements prior to funding being committed.	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	Apr-20	Jul-21	Overdue	2	Partially complete	3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. AI, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further. dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart for ensuring payment is made. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of checklists, quality dashboard and SOPs. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 Escalation of care homes is supported via the local Care Home MDT. Assurance checkes part of the QA assessment for out of county placements in place. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly.	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	Jul-21	29	14	Sep-22	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit. 4.2 The health board should undertake a demand and capacity review in light of the updated processes, in order to ensure compliance with legislation and maintain patient safety.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	Mar-20	Apr-21	Overdue	2	Partially complete	Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, Joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 As part of the restructure of the team in CSG between November 2021and January 2022 the service was re mapped against activity and new pathways and a revised service model was implemented. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly.	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion, reviews completed virtually	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21	29	17	Sep-22	
192016	Organisational Development Strategic Framework	Reasonable	Director of Workforce & OD and Support Services	Assistant Director of Organisational Development	R1	We recommend that action plan entries are developed to carry a greater level of detail to facilitate the monitoring of achievement of priority delivery. This should include detailed actions, by whom they will be delivered, target timescales and where each priority status is to be reported and monitored.	The Executive Directors will develop detailed objectives and actions that will enable the achievement of each of the key priority deliverables within the Organisational Development Framework. For each action there will be action owners or leads along with defined timescales which will ensure the ability to monitor and evaluate progress against each action.	Mar-20	Sep-20	Overdue	3	Partially complete	This work has been paused due to the COVID pandemic and current winter pressures. – However a number of the OD priorities have been included in other plans; such as the wellbeing plan- leadership and team development. JUNE 2022: The ODF was refreshed in 2021 when we were in the midst of the pandemic response. As we come out of the pandemic our focus is on how the organisation and our staff can recover and how we use this opportunity for renewal and transformation of our core services. In parallel to this we have experienced turnover within our Executive Team and Independent Members and it is in this context that we are planning to undertake a stocktake of our progress and engage with our senior leaders and staff side colleagues with a view to developing a detailed action plan to be agreed by our Board in Q2 OCTOBER 2022 Workshop were held with Board and LPF in JUne / JUly. Outcome .Review findings will be considered in Q3/4		This will be reviewed as part of the reintroduction of BAU	end of Qtr 2	10	14	Sep-22	
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance		R1	Create and implement an overarching document that outlines the range of outpatient services and pathways provided by the health board, including the locations where they are delivered. Create and implement a process flow diagram that explains the outpatient referral process, ensuring Patient Services staff are fully aware of the procedures to be followed.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included. PTHB Elective Care patient pathways are managed in accordance with national waiting times standards and good practice is followed to ensure that patients are treated promptly, efficiently and consistently. A Patient Access Policy within the health board will be developed that details roles and responsibilities and sets out the general principles and rules for managing patients through their elective care pathway. WG are currently reviewing national waiting times standards (RTT) in light of COVID19 19 and the impact of new ways of working e.g. digital appointment solutions like Attend Anywhere. The Patient Access Policy will be updated in line with the revised WG guidance once published.	Mar-21	Mar-22	Overdue	3	Partially complete	This work has been delayed due to covid but also now needs to be considered in line with national guidance on pathways and the Powys renewal priorities. This will take until end of the year.	Waiting for overall WG rollout		Mar-23	18	6	Sep-22	Sep-20
192023	Estates Assurance Follow Up	Reasonable	Director of Environment	Asbestos Manager	AM2	A detailed review of the Asbestos Management Plan should be completed.		Jan-21	Oct-22	Deadline Revised	3	Partially complete	Policy now updated and approved with Asbestos Management Plan to be agreed in August Asbextos Management Group	COVID-19 delays	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and introduce site specific management plans.	Aug-22	10	#NUM!	Sep-22	Sep-20
192026	Risk Management and Board Assurance	Limited	Board Secretary	Board Secretary / Head of Risk & Assurance	R5	a. The Board should explore ways to strengthen the Board Assurance Framework as a live and robust assurance tool for its corporate objectives by: • relevant Committees and groups regularly review controls and assurances to assess their effectiveness and identify any gaps; and, • the relevant committees have regular oversight of the strategic objectives and risks assigned. b. Consider enhancement of the Board Assurance Framework review process by implementing and presenting a detailed BAF report at Board meetings. c. Establish the concept of Local assurance frameworks into the risk management hierarchy and then introduce them as a process documentation and discussion at directorate level.	Agreed	Mar-21	Mar-23	Deadline Revised	2	Partially complete	High level work has been initiated to outline the framework and principles.	COVID-19	Agendas for all meetings continue to be scrutinised in order to ensure that the Board is receiving appropriate assurance.	May-22	12	#NUM!	Sep-22	Sep-20
192027	Welsh Language Standards Implementation	Limited	Director of Therapies and Health Sciences	Welsh Language Service Improvement Manager	R3	The health board should continue raising awareness of the Standards, including through: 1. the roll of out awareness sessions, keeping records of attendance; 2. increasing the frequency and content of internal communications; and; 3. the Standards included as a standing agenda item at Directorate and service level meetings to ensure progress against action plans is monitored. 4. Consideration should be given to developing a communications strategy to ensure staff are familiar with the Standards, understand its impact on their roles and the support and resources available to them to comply.	The health board will continue to offer Welsh Language Awareness sessions to staff across all directorates and will record attendance going forward. The health board will explore options for adding this training to ESR in order to record staff training. Opportunities to deliver this training session virtually will be explored in order to reach as many staff as possible across the health board. In addition, the health board will look to increase opportunities to raise awareness of the Standards to all staff across the organisations via a range of communication methods. The health board will continue to liaise with the Assistant Director of Communications to develop and promote a new Communications Guide for staff across the health board which includes guidance on complying with the requirements of the Welsh Language Standards and will offer examples of best practice. A communication strategy will form part of the overarching Welsh language action plan as outlined in the response to recommendation 2 above.	Mar-21	Mar-22	Overdue	3	Partially complete	1. Welsh language awareness sessions are routinely held as part of the corporate induction days on a monthly bssis ensuring that all new staff to PTHB are aware of the Welsh language standards and the support that's available. Awareness sessions are also being held with individual teams across the health board. Data on number of attendees is available. 2. Information on Welsh language standards is routinely sent out to staff via Powys Announcements, emails, social media channels and staff sessions such as the corporate induction. Our new sharepoint pages include comprehensive information on complying with the Welsh language standards as well as information on how to learn Welsh and what support is available. For the launch of our new Sharepoint site all our Welsh language guidance for staff have been updated. 3. An audit by NWSSP has recently been completed on how various departments across the health board are complying with the standards and how Directorates monitor progress against work plans. We expect the audit plan to be completed and targets and deadlines given by November 2022. 4. Building on our current work to increase the content of internal communication regarding the Welsh language standards, we will work with the Communications team to develop a communications strategy for the following year. the startegy will be in place by the end of the financial year (March 30th 2023)	Lack of resources to fully implement the WL Standards. Additional funding requirements for translation costs. Resource and deadline implications for WL team depending on recommendations of audit.	Regular monitoring and reporting via the Executive Lead for WL. Additional resource has been allocated for translation costs.	1 - complete 2 - complete 3 - audit plan to be completed in November 2022 with deadline for the next year 4 - end of March 2023	18	6	Sep-22	Sep-20
202181	Partnership Governance – Programmes Interface	Limited	Board Secretary		R1	The health board should consider developing a partnership governance guidance document defining the different types of partnership/collaborative working arrangements and the governance arrangements required for each. This would assist in identifying the most appropriate arrangement to meet identified needs when seeking to establish a new partnership. The equivalent arrangements in place for Section 33 agreements could be used as a starting point. Partnerships should be supported by a partnership governance framework clearly setting out the objectives and governance arrangements. This should include roles and responsibilities of each partner, performance monitoring and assurance reporting arrangements and escalation processes. A central record of partnerships should be maintained. This should identify the executive lead(s) and assurance reporting arrangements. The record should be referred to when considering establishing a new partnership, to identify whether requirements could be met by an existing partnership in order to avoid potential duplication of effort.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21	Mar-22	Overdue		Partially complete	Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	By March 2023	12	6	Sep-22	

Ref	Title	Assurance	Director	Role	Rec	Recommendation	Management Response	Orig	Rev	Status	RAG	Progress	Update	Risk	Assurance	Due		Score1	Score2	Date
202108	Partnership Governance – Programmes Interface	Limited	Board Secretary		R5	Arrangements for reporting assurance to the Health Board on the effectiveness of the Live Well: Mental Health partnership need to be determined.	Reporting arrangements will be reviewed and clarified through the Partnership Governance Framework development and ongoing implementation. This reporting mechanism will also need to reflect existing reporting arrangements to Welsh Government and the RPB in order to reduce duplication.	Sep-21	Mar-22	Overdue		Partially complete	Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position.	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	By March 2023		12	6	Sep-21
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R1	We concur with management and recommend that early clinical involvement in the second phase of the SPP programme is given a high priority to ensure that all clinical constraints and opportunities are taken into consideration in the development of the strategic changes to Maternity services.	As confirmed by Internal Audit the South Powys Programme Board had already identified this issue through its "Lessons Learned" process for Phase 1. As stated there was clinical membership of the Programme Board and workstreams – although the context was particularly challenging due to COVID 19. Thus, this recommendation is accepted. Clinical membership has been built into the Programme Board and Programme Workstream for Phase 2. However, frontline engagement via midwives is also built into the implementation plan. In addition, the readiness assessment will also cover frontline engagement.	Nov-21		Overdue		Partially complete	Meetings continue to include clinical representation from a frontline, management and Director level across organisations. The focus of Phase 2 has been Maternity and Neonatal with a clinically led workstream established. This approach has been embedded in the programme and will continue. The readiness assessment continues to be updated during the workstream meetings. As reported to the Board on 24th November 2021 it is not yet possible to recommend to the Board the timing of the strategic pathway change as further information is awaited from the Independent Oversight Panel. It will only be possible to complete this action once the timing of the strategic pathway has been approved by Boards.		Workstream in place involving clinicians from ABUHB, CTMUHB and PTHB chaired by the DONM, monitoring existing pathways and assurance.	This cannot be implemented until the Board has agreed the timing of the strategic pathway change. It is not possible to set a revised deadline until the timing of the strategic decision has been reached by Board. UPDATE - revised implementation date to be confirmed during quarter 3 as overall stocktake will be undertaken with the IMSOP review		10		Sep-22
202111	Progress against Regional Plans (South Powys Pathways Programme, Phase 1)	Reasonable	Director of Planning and Performance	Assistant Director, Transformation	R2	We concur with management and recommend the development of a documented framework that the health board can use in future collaborative change programmes to assist in the management of the programme and to ensure the use of a consistent and controlled approach.	This recommendation is accepted and a collaborative change programme framework will be developed and considered through the PTHB Executive Group for Strategic Planning and Commissioning.	Sep-21	Mar-22	Overdue		Partially complete	Standard PIDs have been agreed for the 9 Renewal Programmes including key stages in collaborative change such as identification of stakeholders, engagement and communication, consultation and formal written notice. This will be summarised in a Change Programme Framework and submitted to the RSPB (Executive Committee)	Delayed due to prioritisation of Renewal Portfolio due to pandemic	Individual programme PIDs have set out the stages required.	01/03/2022, however there will be implications for other health boards. This is timetabled to coincide with the change to Strategic Commissioning Framework at Board in March 2022. UPDATE - revised implementation date to be confirmed during quarter 3 as overall stocktake will be undertaken with the		12	6	Sep-22
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R2	2.1 The health board should ensure the update to discharge policies and procedures is undertaken promptly upon confirmation from Welsh Government. 2.2 The health board should engage relevant staff in the update to ensure the documents are easily understandable (using flow charts and diagrams where appropriate). 2.3 The content of this audit report should be considered as part of the update process.	2.1 Agree – cannot action until further consultation. Recent engagement with DU has suggested DTOC will return by end of year. If this is the case policies and procedures will need recommencing & revision if required. 2.2 Flow charts & diagrams of discharge requirements circulated to staff, placed in shared access folders and discussed in team meeting. Will be a standard agenda for assurance of understanding & interpretation by staff. 2.3 The update of any policies will be in line with Welsh Government direction on DTOC and discharge planning, so we are working within national guidelines.	Mar-22		Overdue		Partially complete	Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Policies will be updated when guidelines released to be in line with national requirements.			01/12/2022 Yes via meeting minutes & action logs	6		Sep-22
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R3	3.1 As part of formalising the PFCU business cycles (see MA1), the health board should consider the key performance metrics for patient flow performance (including delayed transfers of care) to be used for reporting at each level within the health board and how frequently these should be reported. 3.2 The health board could refer to the 2017 Audit Wales report (Discharge Planning, Powys Teaching Health Board) in identifying metrics, recognising some of the metrics in that report are only relevant for acute care.	3.1 KPI's and pathways are in situ but "paused" whilst DTOC reporting was stepped down. When recommenced a review of pathways will be held to ensure they are in line with any revised guidelines. KPI's for delays & repatriation times will be developed once the technology supports this – incoming with electronic flow system. 3.2 The HB will focus on national guidelines for step down & step up beds as a mechanism to support the identification and development of metrics - currently working with Hywel Dda University Health Board & the NHS Wales Delivery Unit to establish a cross agency recording system which will lead to a shared data set. Metrics for discharge pathways is already established.	May-22		Overdue		Partially complete	Still awaiting direction from WG, which is expected November 2021. Still awaiting direction from WG, which is expected November 2021. Ongoing work with the delivery unit in regards to newly revised DTOC system which is anticipated for release by November. Will implement guidelines & establish pathways as required. Will ensure KPI's are in line with national requirements when released.			01/12/2022	4		Sep-22
202115	Winter pressures and flow management	Reasonable	Director of Planning and Performance	Senior Manager Unscheduled Care	R5	Given the impact of the Covid-19 pandemic and the ongoing development of patient flow initiatives, the health board should consider undertaking a formal demand and capacity review for staff resource for patient flow.	Seven-day working was stood up during the pandemic where a demand & capacity review was completed for weekend working. As a result, the HB established no demand for seven day working but has a plan to flip if required to seven days. Outside of this flow is managed & workload of CTC's is manageable There is sufficient evidence to support this (i.e. staff within working hours, flow adequate & ability to flex within teams). The HB will consider a demand & capacity review in its longer-term plan.	Jul-22		Overdue		No progress	The Health Board has daily oversight via CTC's on the number of patients requiring repatriation back to Powys. Whilst CTC's are not employed 7 days per week the position on a Monday morning is quickly understood. The Health Board will pick up demand and capcity planning as part of 23/24 overall IMTP planning			Mar-23	2		Sep-22
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R2	Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include: • Using item data from maintenance schedules to populate the e-Quip system, then forwarding e-Quip Inventory records to each site for verification. • Nominated e-Quip 'champions' at each site with access to input data directly to the e-Quip system; • Undertaking site visits; • Sending out e-Quip inventory reports to each site on a half yearly basis for updating; and • Identify additional staff resources on a temporary basis to help populate the e-Quip system.	e-Quip implementation timeframes have been extended to December 2021, from September 2021. Action has been taken in the form of escalation to ensure services engage in the implementation, which is essential to meet the desired outcome. Challenges in terms of capacity are being met but additional resource options are being explored in the form of temporary bank support, student roles and any areas with spare capacity. Should any of these options become available the implementation will gather pace.	Dec-21		Overdue		Partially complete	Now entered the final phase of implementation before transitioning into "business as usual" from 1st November 2022. To enable progression to this stage, additional hours have been approved for 7 weeks in conjunciton with the monthly imports now active from Avensys into e-Quip.	Resource within Medical Devices Team.		It is intended that from October 2022, it will be appropriate to commence routine spot checks and validation of data in conjunction with service leads. However, this will be determined by capacity within the Medical Devices Team. Completion date unknown due to lack of resource		9		Sep-22
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads	R3	All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	All patients will be asked to complete indemnity forms when receiving equipment from the health board. Continuous assurance will be obtained through service governance leads in the form of self-audits. Governance leads will provide assurance to the Medical Devices Group through "At a Glance Reports."	Nov-21	Feb-22	Overdue		Partially complete	Examples of evidence awaited from Governance Leads.	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.	Review of compliance to be undertaken in conjunction with Governance Leads and through MD&POCT Group assurance process. Assurance to be gained from each of service groups by November 2022		10		Sep-22
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Ward Manager – Graham Davies Ward / Governance Lead / Department Leads / Medical Device & POCT Manager	R4	1. Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. 2. A general reminder should be issued to all sites within the Health Board of the requirement to ensure that all medical devices and equipment are stored in a safe, secure location when not in use.	1. Storage will be reviewed at Graham Davies Ward and all options explored. Feedback back on this review will be provided through Medical Device Group "At A Glance Report." 2. A Storage Audit Tool has been in use and was developed with input from Internal Audit following the previous audit. The tool was previously used by Medical Devices Team to audit several sites and services across the health board, this highlighted some areas of good practice but also some areas in need of improvement. Service Leads were notified immediately of any areas of concern in the form of photographs and audit reports. This learning was also shared wider across the health board through various forums, for example, the Medical Devices Group and Capital Control Group. The tool has now been transferred into the format of Microsoft Forms and is embedded within the recently reviewed Policy. The Policy states service leads should be undertaking 6 monthly self-audits. Governance arrangements for this process will be the responsibility of the service group governance leads.	Mar-22		Overdue		Partially complete	CSM has requested urgent engagement with Estates to address this. Update from Ward Manager - new storage unit being built to store equipment.	Delay due to CSM absence.	Risk is being managed locally by CSM and Ward Manager.	Update from Ward Manager - new storage unit being built to store equipment.		6		Sep-22

Ref	Title	Rating	Director	Lead	Rec	Recommendation	Management Response	Date	Revised	Status	Priority	Progress	Update	Further comments	Mitigation	Assurance	Target	Rating	Last reviewed	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Head of Clinical Education / Medical Device & POCT Manager	R5	1. The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. 2. The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	1. Management is committed to making improvements in the recording of medical device and POCT training, for both new devices and refresher. A small group has been set up to progress medical devices and POCT training which includes robust record keeping via ESR. An initial meeting of the group is scheduled for 8th November, this was delayed at the request of Clinical Education as waiting for new members of the team to commence into post. The aim of the group will be to pilot a process for a small number of devices. Once this is in the place, the same process will be rolled out for all devices and all staff groups. 2. Management will ensure manufacturer's instructions are stored digitally via the Medical Devices Intranet page where applicable. Capacity to undertake this task is limited. Responsibility for this role and timeframe for completion to be identified.	Mar-22		Overdue		Partially complete	Training matrix has been developed and shared with Governance Leads for review. TO be shared with MD&POCT Group members in October 2022 and agreed at November MD&POCT Group.	Resource within Medical Devices Team.	Implementation of new devices on a health board basis incorporate training and recording via ESR.	Assurance on devices already in use will take some time to obtain through ensuring all staff are appropriately trained and competent, recieve updates at agreed intervals and that robust recording processes are in place. Gradual progress being made but unable to define a specific completion date due to capacity constraints		8	Sep-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R6	The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (kpi's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (PPM Contracts) • Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	Management will ensure contract meetings are resurrected and KPI's developed and monitored as per contractual arrangements, although capacity does limit this area. The renewal of the main maintenance contract (due 1st April 2022) provides an opportunity to significantly strengthen this area. Standing agenda item will be added to the Medical Devices Group to review contract monitoring and KPI's.	Apr-22		Overdue		No progress	Contract monitoring meetings continue with some providers. Temporary additional resource has been secured and may provide an opportunity to strengthen processes in this area and identify cost savings.	Resource prevents progress in this area.	Contract monitoring meetings held for some providers.	Without any additional support it is difficult to understand how the health board will be in a position to strengthen contract monitoring processes and therefore obtain assurance.		5	Sep-22	
212204	Midwifery – Safeguarding Supervision	Reasonable	Director of Nursing & Midwifery	Head of Midwifery and Sexual Health / Named Midwife for Safeguarding supervision / Assistant Director for Women and Children's services	R1	1. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 2. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	1a. Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months 1b. Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives 1c. Requirements to attend Safeguarding supervision and available dates for Q3 are highlighted through the Midwifery Weekly brief that is shared to all Powys Midwives 2a. Safeguarding supervision compliance will be monitored through monthly Midwifery Management and Leadership Governance meeting and has been included into the Women and Children's Senior Leadership Performance Dashboard 2b. Women and Children's Safeguarding Work plan to be reviewed and updated to ensure improvements with compliance is effectively implemented	Dec-21		Overdue		Partially complete	Ongoing highlighting to midwives at a range of forums re compliance with safeguarding supervision. Lead midwife for safeguarding to commence in post 29/08; workplan to include support for supervision. * Rachel Mills lead Safeguarding Midwife will attend monthly Management & Leadership meetings to update the team on Safeguarding cases. * Abbi Maddox Interim Head of Midwifery & Sexual Health to meet with Rachel Mills Safeguarding Midwife on a monthly basis to be sighted on training and required updates. * Learning to be embedded through Joint Shire Meetings with Midwifery & Health Visiting services using Safeguarding scenerios on a quarterly basis.	Issues regarding release of staff due to staff shortages/clinical demand Limited number of sessions which are not always available when convenient for all staff to attend	request that team leads allocate protected time for staff to attend which is rostered, preventing clinical work to be allocated to individual. Lead midwife for safeguarding, to commence in post 29/08, who will support midwives to attend Midwives aware can access safeguarding team re any concerns about specific cases	Expected improvement in compliance by end of Q3; Monitored via Safeguarding Strategic Group and added to W&C dashboards.		8	Sep-22	
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Medical Director	R1	Further work should be undertaken to take forward the consideration regarding appointment of a part time Clinical Director for Endoscopy and Theatres to improve the oversight and discussion of clinical issues. Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board	To explore opportunities for a Clinical Director role for Planned Care (including Endoscopy and Theatres)	Mar-22		Overdue		Partially complete	Being considered at present and as part of planning for 23/24	Unable to fully mitigate the risk	During current financial year	01/03/2023		6	Sep-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director of Community Services Group	R2	Progress on delivering the Theatres and Endoscopy Recovery Plan should be appropriately controlled and monitored to ensure that the 2021/22 Renewal Priorities are achieved.	Further work should be undertaken to take forward the consideration regarding repatriation and staffing of Theatre and Endoscopy services by the Health Board.	Mar-22		Overdue		Partially complete	currently being scoped. Will need additional finance to resolve or diversion of funds allocated to Health Boards 'back' to afford delivery	Currently waiting for NHS Wales DU to assemble patient lists to enable selection from other HB waiting lists (for potential repatriation)		01/03/2023		6	Sep-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director Community services	R3	The Service Level Agreements for the in-reach staff should be reviewed and updated as soon as possible.The assumptions and calculations within management information should be reviewed and updated as soon as possible. Agreed Management Action 3	To review service level agreement with in reach providers, this is challenging due to current seasonal pressures focus and all providers re-aligning/transforming services and implanting recovery plans. Management reports will be aligned with updated SLAs as part of 2022/23 service planning.	Mar-22		Overdue		Partially complete	All SLAs to be by the end of Sept as part of managing the overall financial position of the HB. Update - revised focus at CQPRM meetings will see SLA performance discussed more frequently including supplementary operational meetings. There remains a certain level of fragility in the inreach relationships due to at times, a higher level of need within the host provider			01/03/2023		6	Sep-22	Jan-22
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Planned Care Manager	R5	The Health Board should develop a protocol which describes the administrative processes which are in place regarding theatre utilisation.	Terms of Reference for Theatre Planning Meeting will be formalised and admin processes for list planning added to the SOP.	Jan-22		Overdue		Partially complete	Terms of Reference are now in place. Utilisation picked up as part of GIRFT review.Operational theatre report to be revamped in line with GIRFT expectations			Dec-22		8	Sep-22	Jan-22
212206	Dementia Services- Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Assistant Director of Mental Health Services	R1	The operating environment within both teams needs further evaluation, to ensure clients have consistent access to services throughout the Health Board and good practice can be shared and embedded.	The configuration of the North Powys team to match the clinical specialism of the South will require additional funding, as well as any move to the South Team matching the North's 7- Day working practices. Elements of this funding will be considered as part of the Mental Health Service Improvement funding and any additional funding released by Welsh Government.	Sep-22		Overdue	Low	No progress	At present, funding to enable the expansion of the team to accommodate 7 day working. This will be considered within the overall MH model of care through the MH Transformation work that commences in September 22.	Additional financial resources are required in order to operate the service on 7 day basis.	Should patients deteriorate over weekend, inpatient and MHA processes are available.	7 day working for the DHTT will be considered as part of the Mental Health transformation work. Completion date will exceed the agreed deadline for this action.		3	Sep-22	Jan-22
212207	Dementia Services- Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Operations Manager, Mental Health Services	R2	The draft policy should be updated to ensure it captures the operating environment of both teams and is approved by an appropriate forum/committee.Consideration should be given to producing standard operating procedures within both teams that should clarify the process for the operational updating of the WCCIS System.	The draft policy will be finalised by April 2022, and until additional funds are available to operate the South Team on a 7 – day basis we will require two flow charts demonstration patient flow and the method of referral.The SOP requires finalisation and until full expansion of the service will require two sections, relating to North and South Powys. This will include an update on WCCIS forms to be utilised, however, it should be noted that this work is conducted on an all-Wales basis and all agencies using WCCIS are required to agree to the same forms and processes.	Apr-22		Overdue		Partially complete	Strong progress has been made on the SOP, and updating WCCIS forms is underway. However, these need to be agreed at a national level before they are implemented.	Authorisation of new forms at a national level.	Paper forms are currently in use.	TBC - as working to national WCCIS team deadlines.		3	Sep-22	Jan-22
212207	Dementia Services- Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Business Manager, Mental Health	R4	Management must ensure that the Performance measures are subject to appropriate independent review prior to submission.Good practice in data collection should be shared between the teams.	This process will be reviewed to ensure that Performance Measures are independently and rigorously tested prior to submission.The MHLD business manager will facilitate the sharing of good practice within data collection, including a common method to capturing and processing information.	Mar-22		Overdue		Partially complete	Significant work has been completed in relation to this action, in terms of data cleansing. From April 23, New National MH outcomes mreasurements will be implemented across Wales, and the MH team are working towards this implementation. During the period October to March 23, the service will be preparing to embed the new performance measures.	Developments are required to WCCIS on a national level to capture this data.		Mar-23		3	Sep-22	Jan-22
212207	Dementia Services- Home Treatment Teams	Reasonable	Director Primary, Community Care and Mental Health	Assistant Director of Mental Health Services	R5	A review of the performance measures should be undertaken to ensure they are meaningful, and duplication is avoided.Guidance on how to interpret and evidence the performance measure should be provided. Management should consider standardising the performance measures across both teams to ensure meaningful and comparable information is collected.	The review of performance measures will be undertaken as part of a wider MHLD service group's participation in Welsh Government's move to service user led outcomes and core data sets.Within the National move to service user led outcome and data sets, training for staff and managers on its collation and interpretation will be facilitated on a National Basis, and PTHB are currently involved in this work.Local performance measurements will be developed and utilised on a pan Powys basis to improve performance and ensure that consistent, accurate and meaningful information is collected to improve performance.	Sep-22		Overdue		Partially complete	Please see above as this is a similar reccomendation.	See above.	See above	Mar-23		3	Sep-22	Jan-22
212208	Waste Management	Reasonable	Director of Environment	Service Improvement Manager	R1	The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The THB should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements. The new document, once approved, should be published online. Superseded documents should be removed from the intranet.	Agreed. The core document is already in place and is currently out for consultation with Waste Group members. Agreed. The updated document will be signed off as a Policy at Executive Committee.	May-22	Dec-22	Deadline Revised		Partially complete	Some further changes to the document are required. The document will then go through the process that will close with consideration by the Board. We have reviewed the document following completion of our contract award, but also reflected on progress in other HBs -and our document will be finalised and through necessary governance by December 2022	Obtaining an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the revised document by the Board. Extention to deadline requested due to committee timetables.	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	Nov-22		4	#NUM!	Sep-22	Apr-22
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R1	Management need to ensure that both the Occupational Health Policy and Needlestick & Body Fluid Contamination Injuries Policy are updated and approved in a timely manner.	The Policy for Needlestick and Body Fluid Contamination will be reviewed and presented for Executive approval.The Occupational Health Policy will be reviewed and presented for Executive approval in Quarter 2 2022	Jun-22		Overdue		Partially complete	Policy for Needle stick and BF reviwed and approved at execs on 13th July. Generic OH policy currently being reviewed;. OCTOBER 2022 - Operational delay in obtaining comments back on draft OH generic policy before submitting to Execs for sign off - Policy will be scheduled for Nov exec	Capacity within the OH team has meant this has only partly been achieved		Generic OH policy review will be ready for consultation / comments end Aug with view to approval by execs in Sept	Exec meeting 13th July NS and BF policy approved	3	Sep-22	Aug-22

Ref	Title	Assurance	Director	Lead	R	Recommendation	Management Response	Agreed Date	Status	Completion	Progress Update	Risk	Barriers	Timescale	Evidence	Count	Date 1	Date 2
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R?	Management within the Occupational health service need to ensure that employees are seen on a timely basis to ensure that any medical conditions which are affecting an employee's ability to carry out their duties is addressed on a timely basis.Management need to train staff on the completion of referral forms to ensure that the staff receive the appropriate support required or send them back requesting them to be completed correctly. Management may wish to consider drawing up guidance for the completion of the form or the use of a schedule of Frequently Asked Questions for staff to access.	The Occupational Health Team will develop a set of KPIs for timelines and monitor compliance relating to OH referrals and appointments (this will be developed once the additional resources are in place). Develop a 'manager's guide' and work with Workforce Business Partners to provide support and guidance for the completion of referrals.	Sep-22	Overdue	Partially complete	KPIs for timelines are in development; utilising data from Cohort reports. Update on referrals; volume and timelines were verbally reported at H&S group 10.10.22 Managers guide in draft from and due to be released end of October. Employee Relation Team, will cascade through service mgt structures.	The inability to recruit to the 1.4 WTE OH vacant posts has contributed to delay in full progress of these actions.	Work on the KPIs are being developed but not at the intended pace due to resources	Once resources have been recruited to : estimated Q4		0	Sep-22	Aug-22
212214	Occupational Health Service	Limited	Director of Environment	Assistant Director of Support Services	R5	The Health Board need to ensure that Health Surveillance is embedded within the Health Board so that a review of all staff that require health surveillance is undertaken and those that require it are assessed as and when required in compliance with Health and Safety Executive requirements. Management need to ensure that Hiring Managers are aware of the need to complete the Health Surveillance section on the pre-employment check form.	A 'task and finish' review of roles that require health surveillance will be commissioned through the Health & Safety Group, chaired by the Assistant Director for Support Services. Departmental and Service representatives will be asked to submit roles in their department that are subject to Health Surveillance for the risks identified in H&S regulations. The group will review Job Descriptions for the said roles to ensure that Health Surveillance requirements are reflected in the role, and to advise Occupational Health. Hiring managers will be reminded via a communication to be cascaded through the Deputy and Assistant Directors of the requirement to complete the Health Surveillance section of the Pre employment check form. Workforce Business Partners and Assistant Business Partners will also be asked to remind hiring managers of the importance of completing this section too.	Sep-22	Overdue	Partially complete	A proforma for assessing roles for Health Surveillance has been developed and is in use. All Job Matched job descriptions in Estates, Support Services and Operating Theatres have been assessed against each of the Health Surveillance domains. Occupational Health have received this feedback. Maternity, Radiography and Dental will be asked to do the same for all job matched roles in those departments. This will complete review of the departments with significant Health Surveillance risks. The Health Surveillance working group will take advice on which departments should be approached next, if any. Communications have been circulated regarding the refreshed Health Surveillance Occupational Health checking forms for new starters.	None identified	Implementation Underway	Oct-22	Evidence of work completed to date can be provided.	0	Sep-22	Aug-22
212218	Recommendation Tracking Process & Follow Up Review	Substantial	Board Secretary	Head of Corporate Governance Manager	R1	Going forward, management should work with the Committee members to consider ways in which the level of scrutiny and challenge, particularly around overdue recommendations, can be increased. This could include requiring the relevant Executive leads to attend the Committee to provide further assurance around the plans in place to ensure implementation of overdue recommendations.	The Board Secretary will work with Committee members to encourage and increase the level of scrutiny and challenge in relation to audit recommendations, particularly those overdue. A review of long-standing overdue recommendations is being undertaken and where considered appropriate Executive Leads will be invited to the relevant Committee to provide further assurance around progress and plans in place. As an example, an update on Records Management is to be reported to the next meeting of the Delivery of Performance Committee.	Jul-22	Overdue	Partially complete						2	Sep-22	Aug-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R3	The health board should review the mechanisms that it has in place to provide assurance that Powys residents commissioned to other providers in order to demonstrate that patients are treated fairly and equitably, and to ensure these are articulated in the CAF Escalation Report. This should include reference to anomalies that might be caused by potential variations in the types of clinical treatments, availability of certain specialist consultants (including, for example, the number of sessions delivered by speciality against the number of sessions required).	The CAF report sets out the RTT position for Powys patients in each of the different providers attended (due to geography) even though the waiting times are different. The waiting time differences are recorded in the public domain. Audit recommends showing that Powys patients are being treated the same as the other patients in those health boards and NHS Trusts by showing the overall performance of those organisations. However, this would not offer assurance as a small number of Powys patients attend some of the specialities provided in a provider. The Powys specific figure would not be the same as the overarching RTT performance figure for the provider. Our English providers report as organisations against the English targets. Recommendation partially accepted. We will review the mechanisms in place but not the specific suggested action regarding comparison with the providers' overarching RTT performance figures. Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Mar-22	Complete	3	Complete		The Health Board now reports waiting list performance to D&P committee and Board. The enhanced reporting is a resident view by provider by waiting list duration	COVID-19 delays		Sep-22		18	6	Sep-22	Sep-20
192022	Outpatients Planned Activity	Reasonable	Director of Planning and Performance	Assistant Director Performance and Commissioning	R4	Continue to work with the commissioned health boards and trusts in Wales and England to enhance the reporting of commissioning services data to include Powys outpatient follow-up appointments waiting times and to discuss exceptions with them.	Implementation will inevitably be dependant upon the health board's position in relation to COVID-19. An indicative implementation date of 31 March 2021 has therefore been included.	Mar-21	Jan-22	Complete	3	Complete		As reported to EQS and P&R committees the CAF has been partially reinstated. Work is underway to ensure information about follow-up. Further information is now being reported by acute hospital sites for follow up performance including those overdue. Information will be included in the next D&P Committee Report. UPDATE - now complete as per above action		Follow-up is discussed in CQPRMs.	Sep-22		18	8	Sep-22	Sep-20
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing	R1	Consideration should be given by management to updating the policy to reference the recommended number of members for job evaluation panels and the make up of the panel members.	The job evaluation policy will be reviewed by the Workforce Policy Review group to consider this recommendation.	Jan-23		Complete		Complete		JUNE 2022: Recommendations on minimum panel levels have been suggested as part of a review of job evaluation activity. However, this is subject to approval through the organisations Workforce Policy Review Group. October 2022 - The policy will be updated and taken to the Workforce Policy Review Group for approval.	Interdependency in relation to approval via the Workforce Policy Review Group		On track for agreed implementation date if not sooner		#NUM!	#NUM!	Sep-22	Apr-22
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing, Executive Director Workforce and OD and Deputy Director of Workforce	R2	Management should consider undertaking an evaluation that would determine the numbers and type of staff (management and staff side) required to deliver an effective job matching service. Representatives for all directorates need to be trained in job matching; this would ensure fairness in release time and allow wider ranging views to be included within the job evaluation process. Management need to highlight the matter of staff not being released to attend Job Evaluation Panels at the appropriate forum so appropriate action can be agreed to address the issue.	A further evaluation of the number of required job matchers will be undertaken by the Job Evaluation team. A formal request to the Executive Team to release staff from each Directorate to participate in job matching training will be undertaken, to ensure that panels consist of a cross section of staff from across Directorates and where possible, differing staffing groups, recognising that this is likely to be more challenging in clinical staffing groups. Where staff are trained and subsequently are not released to attend panels, this will be escalated to the Deputy Director of Workforce & OD.	Jun-22		Complete		Complete		JUNE 2022: An evaluation of the level of activity and required number of trained job matchers has been undertaken and shared with the Deputy Director of Workforce & OD and is awaiting formal agreement of the recommendations put forward. This includes identification of additional resource needed from directorates to support job matching activity as well as recommendations in relation to escalation points. There were no matters to escalate to the DDWOD as part of this review however, the review did identify the requirement for additional resource to be released from a number of directorates. OCTOBER 2022 - Two further training sessions have taken place with new panel members now attending job matching. Further training will be available. There is a spreadsheet available to monitor where panel members are from and the number of panels they are attending.	The Workforce & OD team have identified the required resource based on an evaluation, however, this requires the support and release of staff from across directorates. If this is not provided, there is an ongoing risk that the health board job evaluation capacity may be impacted upon.	Current capacity is being provided via the current JE matchers, of which over half are from within the WOD directorate. This is being mitigated through the consistency checking process on an interim basis but it is acknowledged that this does not provide a wide variety of view points to the process. Further training sessions have taken place with new panel members now undertaking panels.	end of Qtr 2 / beginning of Q3		3		Sep-22	Apr-22
212209	Job Matching and Evaluation Process	Reasonable	Director of Workforce and Organisational Development	Senior Workforce Business Partner - Resourcing	R3	Membership of the job matching panels should be representative of the Health Board and be as independent as possible. Staff should be reminded of the importance in sending the outcomes from panels to management within an appropriate timeframe.	Wider participants will be sought for job matching panels from across the health board's Directorates. Wherever possible, panels will have representatives from outside the Directorate for the role being evaluated, other than on rare occasions where this is not possible and would cassue an unreasonable delay providing an outcome. Oversight and monitoring will be reviewed to ensure that are outcomes are provided within reasonable and agreed timeframes.	Jun-22		Complete		Complete		JUNE 2022: The evaluation undertaken as part of recommendation 2 included a recommendations to source resource from directorates across the organisation and therefore, subject to approval of the recommendations and subsequent actions as agreed this action will be complete. OCTOBER 2022: - There is a spreadsheet available to monitor which directorate panel members are from and this will be continued to be monitored. Job evaluation monitoring processes are in place and monitored to ensure outcomes are delivered in a timely way.		Current monitoring would suggest that outcomes are being released within the agreed timeframes. Current capacity is being provided via the current JE matchers, of which over half are from within the WOD directorate. This is being mitigated through the consistency checking process on an interim basis but it is acknowledged that this does not provide a wide variety of view points to the process. Further training sessions have taken place with new panel members now undertaking panels.	end of Qtr 2 / beginning of Q3		3		Sep-22	Apr-22
212210	Mortality Review	Reasonable	Medical Director	MDT review panel	R6	Management should ensure that going forward, all relevant staff are made aware of any issues raised by either the Medical Examiners Service or the Multi-Disciplinary Team, with clear and concise feedback provided and reported. A record of all issues that are identified should be recorded so that patterns / trends can be recognised and addressed.	This will be recorded on datix mortality review and shared via the MDT review panel and learning group.	ongoing		Complete		Complete		See R5. Themes will be discussed in learning group. Methods for staff feedback have been agreed by the learning group. 14/10/22 Processess in placewith defined methods of shared learning and feedback			Feb-23		#VALUE!		Sep-22	Apr-22

222302	Site Leadership and Coordination (Advisory)	Not Rated	Director of Environment	Director of Environment	R1	An appropriate site coordinator for the Machynlleth Hospital should be identified as soon as possible.Management may want to consider the identification of deputy site coordinators noting that the role would only be required should the 'lead' site coordinator have an extended period of absence e.g. long term sickness, maternity leave.Management should consider discussing the role of the site coordinators at the next Site Coordination Forum to ascertain how they feel the role is working, noting any concerns they have. From this meeting site coordinators should be clear on what is expected of them.	This was a temporary gap due to change in personnel in senior roles. Following recruitment to these roles a site coordinator has been identified and confirmed. In line with the formation of the model, it is the expectation that the coordinators are drawn from the service groups within the Director of Primary Care, Community and Mental Health portfolio. Due to the number of sites identified from senior managers within these groups it would not be possible to have formal deputies. It will be agreed that relevant Assistant Directors must flag up to the Director of Environment at the earliest opportunity any long term absence to consider the need for a temporary replacement. It is the view of the Director that there is clarity on this role however this observation (as part of this report) will be discussed with Coordinators at the next meeting. A specific meeting to discuss this is not necessary.	Sep-22	Complete	Complete	0	0	Sep-22	Sep-22
222302	Site Leadership and Coordination (Advisory)	Not Rated	Director of Environment	Director of Environment	R2	Where sites have multiple site coordinators consideration should be given to holding a joint 'local' site coordination meeting where all departments based at the main hospital site can attend.	This scenario exists on three sites only (namely Brecon, Welshpool and Newtown). This opportunity will be discussed with the relevant site coordinators at the next meeting on 12th September to consider if there is a need or merit.	Sep-22	Complete	Complete	0	0	Sep-22	Sep-22
222302	Site Leadership and Coordination (Advisory)	Not Rated	Director of Environment	Director of Environment	R3	Prior to each meeting of the site coordination forum management should consider circulating the action log to all members requesting them to provide an update on any progress made for any actions that they have been assigned. The meeting admin support should then coordinate the updates provided and update the action log.	The first meetings have been supported by various admin support. This task is now undertaken by the PA to Director of Environment. It is agreed that the process above should be standard practice	Ongoing	Complete	Complete	#VALUE!	#VALUE!	Sep-22	Sep-22
222302	Site Leadership and Coordination (Advisory)	Not Rated	Director of Environment	Site Coordinators	R4	Management should remind all site coordinators that if they are unable to attend the site coordination forum the site highlight report must be submitted for consideration/noting at the meeting.	This will continually be reminded to the Coordinators. It is the clear expectation of the Director that coordinators hold local site meetings in advance of the Coordination Forum meeting (every 2 months) and provide written reports at the meeting. If Coordinators cannot attend the Forum they must provide written reports.	Ongoing	Complete	Complete	#VALUE!	#VALUE!	Sep-22	Sep-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress being made to implement recommendation				If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past Revised deadline	Reporting Date	Date Added to Tracker
														Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?					
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Medical Device & POCT Manager	R1	1. A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. 2. The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. 3. The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	1. Management will ensure a review of the purpose of the Preferred Equipment List is undertaken. How it is maintained and kept current will be part of this review. Both Procurement and Finance support will be required for this review. 2. There is currently a section within the EDOF stating NWSSP Procurement must be involved. However, management will ensure this is strengthened by adding a specific field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. 3. Management will ensure all EDOF's not fully completed will be returned to the requesting service for completion.	Nov-22		Not yet due		Partially complete		A Teams Channel has been created for for both Medical Devices Team and Procurement to access and update the preferred equipment list. This work includes any All Wales contracts being added by Procurement.	Resource within Medical Devices Team.	Regular meetings and monitoring with Procurement. EDOF process monitors equipment being requested.	This will remain an ongoing action as the preferred equipment list requires constant monitoring and updating in conjunction with Procurement.		#NUM!	#NUM!	Sep-22	
212203	Medical Equipment and Devices	Reasonable	Director of Therapies and Health Sciences	Governance Leads / Medical Device & POCT Manager	R7	1. Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy. 2. Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 3. A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.	1. Actions and improvements will be made through the POCT Group. Processes will be implemented for monitoring compliance and will be developed through the POCT Group in collaboration with service group Governance Leads. 2. The Management of POCT policy will be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form is already included in the Management of Medical Devices and Equipment Policy. Will be raised through POCT Group in relation compliance with policy. 3. All new POCT devices will have SOP's in place prior to implementation. The management, in conjunction with Governance Leads, will ensure all current Point of Care Testing Devices have SOP's in place and that they are regularly reviewed and updated accordingly. This work will be implemented through the POCT group.	Dec-22		Not yet due		Partially complete		WPOCT implemention will strengthen governance in terms of quality control checks. WPOCT project has commenced but not completed. Project Manager role has progressed but delay in IG approval has impacted on being able to deliver within a specified timescale.	Resource prevents progress in this area.	Awareness raised through Governance Leads of the importance of quality control checks and robust recording, abeit currently in manual format.	Funding has ceased for the Project Manager role, and following IG delays this has significantly impacted implementation. Gradual progress is being made in WPOCT implementation for INR devices across all sites; revision of timescales in light of project manager funding ceasing is underway. This role will need to be absorbed within the MD&POCT Team.		#NUM!	#NUM!	Sep-22	
212206	Theatres Utilisation	Reasonable	Director of Planning and Performance	Assistant Director of Community services	R4	The actions put in place should continue to be monitored to ensure that they mitigate the risk of failing to achieve access targets including Referral to Treatment and National Endoscopy Programme Joint Advisory Group Training Site re-accreditation.	Plans in place monitored via Delivery & Performance Committee and Diagnostics, Ambulatory Care & Planned Care Board Programme, PTHB Integrated Performance Report.	Ongoing		Not yet due		Partially complete		Additional reporting in place and PTHB continues to review compliance against JAG standard. 1 unit now JAG accredited with the 2nd unit seeking accreditation during 22/23			01/03/2023		#VALUE!	#VALUE!	Sep-22	Jan-22
212210	Mortality Review	Reasonable	Medical Director	MDT review panel/learning group	R5	With the Medical Examiners Service shortly taking over the process of providing Stage 1 mortality reviews, the Health Board may want to use the Learning from Experience Group for discussing any feedback that is provided to identify whether there are any issues that could be quickly resolved i.e. missing documentation, illegible notes, missing patient / doctor information. Likewise, the Health Board may want to consider reporting Stage 2 reviews to the Learning from Experience Group in the same way.	Learning will be fed back to individuals and teams where appropriate. Themes and significant issues will be discussed and shared more generally via the MDT review panel and learning group.	ongoing		Not yet due		Partially complete		This has been considered I the learning from experience group. The MDT review team is under development with the first cases to be discussed by the learning group as pilot. Several methods of feedback have been agreed - including power hour presentations, 7 minute briefings and Q&S newsletter. These will be rolled out as the ME process procedes. 14/10/22 Processes defined and in place, ME service not fully implementated across the Health Board. As numbers raise systems are in place for learning and feedback			Feb-23		#VALUE!	#VALUE!	Sep-22	Apr-22
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R4	Management need to ensure that all prospective employees are cleared on a timely basis following receipt of the pre-employment questionnaires so that they can commence employment as soon as possible.	Develop a set of KIPs and implement monitoring of compliance against timelines relating to Occupational Health Pre-employment checks	Oct-22		Not yet due		No progress		Appropriate KPIs will be developed following 3 month period of monitoring trends Sept-Nov.	hold up in system is immunisations declarations -and timeliness of employees returning information – Reliance on managers to chase employees to source and send information to OH	Pre-employment checks are now triaged within 3-4 working days.	End Q3		#NUM!	#NUM!	Sep-22	Aug-22
212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R6	Management should consider developing the current dashboard to include any indicators around timeliness of services provided by Occupational Health.	Occupation team will develop a set of KIPs to be included in the Occupational Health reporting dashboard for: • Timelines and compliance relating to OH referrals and appointments • Timelines and compliance relating to OH Pre employment checks	Oct-22		Not yet due		No progress		Detailed dashboard yet to be developed- Reliant of above KPI data sets to be fully in place	This information will then be included in the Monthly HR workforce dashboard	Verbal updates at H&S group Data on referrals and PECs to be included when available in WOD workforce performance report dashboard	End Q3		#NUM!	#NUM!	Sep-22	Aug-22
212216	Risk Management & Assurance	Reasonable	Board Secretary		R1	Future iterations of the Risk Management Framework should be supported by an awareness exercise and ensure dissemination of the documentation to Directorate senior management so they can cascade the information to their staff accordingly and reduce the potential of inconsistent or inadequate risk management practices across the Health Board.	Recommendation Accepted It should be noted, however, that members of the current RAG are aware of the risk management framework, as are all Board members. Wider awareness throughout the organisation can always be improved and accept that future iterations should have a proactive awareness exercise in place to support them.	Dec-22		Not yet due		No progress							#NUM!	#NUM!	Sep-22	Aug-22
212216	Risk Management & Assurance	Reasonable	Board Secretary		R2	A programme of risk management training should be rolled out across all tiers of Health Board management and staff so as to provide theoretical and practical knowledge to support the content of the Risk Management Framework.	Recommendation Accepted A proposed approach was considered at the RAG on 5 July with further development of training material agreed to be presented back to its next meeting prior to roll-out into the organisation to relevant groups. Risk Management Training is available for staff to access via ESR but a more tailored approach to the Health Board's specific requirements is required and in development.	Oct-22		Not yet due		No progress							#NUM!	#NUM!	Sep-22	Aug-22
212216	Risk Management & Assurance	Reasonable	Board Secretary		R3	The Corporate RAG ToR document should be updated accordingly to reflect organisational changes and approach to risk governance since 2019.	Recommendation Accepted The TOR of the RAG were considered at its meeting of 5 July 2022 and it was agreed that generally they remain fit for purpose. However, a wider review of risk management arrangements is due to conclude in November 2022 when the review of the Risk Management Framework is due to be reported to the Board of which the role of RAG will be updated as required.	Nov-22		Not yet due		Partially complete							#NUM!	#NUM!	Sep-22	Aug-22

ID	Title	Rating	Responsible	Team	Rec	Recommendation	Management Response	Date	Status	Completion	Narrative 1	Narrative 2	Narrative 3	Narrative 4			Date 1	Date 2
212216	Risk Management & Assurance	Reasonable	Board Secretary		R4	The role of the Audit, Risk & Assurance Committee in receiving and monitoring the Corporate Risk Register should be confirmed and the ToR should then be updated if required. The Committee should then receive appropriate reports in accordance with the confirmed role and ToR.	Recommendation Accepted This will be clarified during the next quarterly reporting cycle.	Oct-22	Not yet due	Partially complete					#NUM!	#NUM!	Sep-22	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R1	The Programme Initiation Document should be updated to reflect the frequency of the Programme Team / Programme Board meetings	PID to be updated to include frequency of meetings in line with RSPB requirements. PID to be agreed by Breathe Well Programme Board at September 2022 meeting and then approved by RSPB thereafter.	Oct-22	Not yet due	Partially complete	PID updated to address issues identified through Internal Audit and to reflect change from RSPB to Transformation & Value Group Executive Committee. Draft PID shared with Breathe Well Programme Team on 14/09/22 for comment and considered for approval by Breathe Well Programme Board on 30/09/22. Updated PID will go to Transformation & Value Group Executive Committee in November for final approval.	Managed through Breathe Well programme governance	Approved by Breathe Well Programme Board on 30/09/22 and will then go for Executive Committee approval on 9 November 2022.	The updated PID, Breathe Well Programme Team and Breathe Well Programme Board minutes and the Transformation & Value Group Exec Committee minutes can provide evidence.	#NUM!	#NUM!	Sep-22	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R2	Management should ensure that an appropriate audit trail is maintained of all changes agreed/proposed to activities listed in the programme plan.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	Oct-22	Not yet due	Partially complete	Programme plan narrative will be updated for Breathe Well Programme Team on 14/09/22 and for approval by Breathe Well Programme Board on 30/09/22.	Managed through Breathe Well programme governance		Programme Plan will provide evidence.	#NUM!	#NUM!	Sep-22	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R3	Management should ensure that more detailed information is outlined within the progress tab in Phase 2 of the Programme Plan. The live document should be utilised to keep up to date information which provides accurate and descriptive records which is reported to the Programme Board and advises them of the current status of each work activity within the Breathe Well Programme. Where work activities are deemed as complete, there should be more detailed information within the Progress Tab to validate this.	Fuller narrative to be included within the programme plan as part of progress updates and this will be scrutinised by the Programme Team and the Programme Board as part of the sign off process.	Oct-22	Not yet due	Partially complete	Programme plan narrative will be updated for Breathe Well Programme Team on 14/09/22 and for approval by Breathe Well Programme Board on 30/09/22.	Managed through Breathe Well programme governance		Programme Plan will provide evidence.	#NUM!	#NUM!	Sep-22	Aug-22
212217	Breathe Well Programme	Substantial	Director of Therapies and Health Sciences	Transformation Programme Manager	R4	Management should update the Project Initiation Document (PID) to reflect the current workstreams. The revised PID should then be submitted for formal approval at the appropriate meeting.	PID to be updated to reflect the current workstreams. PID to be agreed by Breathe Well Programme Board at September 2022 meeting and then approved by RSPB thereafter.	Oct-22	Not yet due	Partially complete	PID to be updated to address issues identified through Internal Audit and to reflect change from RSPB to Transformation & Value Committee Meeting (name TBC). Draft PID scheduled for comment by Breathe Well Programme Team on 14/09/22 and for approval by Breathe Well Programme Board on 30/09/22.	Managed through Breathe Well programme governance	Approved by Breathe Well Programme Board on 30/09/22 and will then go for Executive Committee approval on 9 November 2022.	The updated PID, Breathe Well Programme Team and Breathe Well Programme Board minutes and the Transformation & Value Group Exec Committee minutes can provide evidence.	#NUM!	#NUM!	Sep-22	Aug-22
212218	Recommendation Tracking Process & Follow Up Review	Substantial	Board Secretary	Head of Corporate Governance Manager	R2	Noting that the identified instance has been corrected, management should ensure that sufficient checks are undertaken on the Report and appendices so that all future recommendations are accurately recorded.	Checks are undertaken as part of the reporting cycle, but we note this oversight and will ensure that sufficient checks are undertaken to avoid future instances.	Ongoing	Not yet due	No progress					#VALUE!	#VALUE!	Sep-22	Aug-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R1	A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.	Original replacement plan was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Secured DPIF Capital funding in 21/22 to help improve and enhance current infrastructure (but not to fully rectify and resolve), global market conditions and supplier delays resulted in alternative plans being deployed (linked to infrastructure development) to maximise use of the funding as available within time constraints. Further DPIF bids are being prepared for submission in 23/24 and beyond. There are also plans to move to the HCI platform to allow the legacy equipment to be decommissioned. This will also improve power and cooling. A realistic infrastructure replacement plan is being developed linked to the 4C report and this will be across a number of years and potential funding sources available.	Mar-23	Not yet due	Partially complete					#NUM!	#NUM!	Sep-22	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R2	The risk associated with old equipment should be fully explained at the corporate level. The failure to utilise the end of year funding to remove old network devices should be stated to the Delivery and Performance Committee.	As Above 1.1 and regular updates are provided to the Exec Director of Finance, and as part of the Digital First updates to D&P committee. Partly Agreed - The comment to D&P was to recognise the investment made and how this has helped to improve the position (replacement kit / solar winds etc) but was not to say that all issues are fully resolved. Required plan and action will be across a number of years. This is also reported in the delivery against plan as part of the Digital First objective 'Digital Infrastructure' on the IMTP. Will also be updated as part of a Digital Board Development Day	Dec-22	Not yet due	Partially complete					#NUM!	#NUM!	Sep-22	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R3	Alerts should be configured within devices to enable active management. The thresholds for the alerts should be set accordingly. The Health Board should utilise Solar Winds to manage alerts.	Monitoring of the network is led by the Digital Transformation Team (previously under S33 arrangements) and this has been enhanced by the deployment of Solar Winds (secured with DPIF funding in 21/22), continued action in place to fine tune the configuration to maximise functionality and enable proactive alert management. Thresholds are regularly reviewed and improved to allow effective management of alerts and issues as reported.	Dec-22	Not yet due	Partially complete					#NUM!	#NUM!	Sep-22	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R4	A process for ensuring patching of switches should be established.	Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid.	Mar-23	Not yet due	No progress					#NUM!	#NUM!	Sep-22	Sep-22

222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation / Assistant Director of Estates and Facilities	R5	Fire and water detection should be included at both sites. Consideration should be given to providing a dedicated power supply to the Bronllys room. Fire suppression should be installed at Brecon. The air conditioning within Brecon should be reviewed to ensure it is capable of reducing the temperature appropriately.	Fire detection and suppression are in place at Bronllys, but no water detection. Air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient There are plans to move on premise servers held within the Data Centre to the cloud so this will reduce the risk of on-premises DC's.A plan will be developed with Estates and Facilities to assess the water detection requirements and to test and provide assurance relating to the power requirements (initial meeting already taken place).	Mar-23	Not yet due	No progress					#NUM!	#NUM!	Sep-22	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R6	A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network A review and associated upgrade of Wi-Fi provision should be undertaken	Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Mar-23	Not yet due	No progress					#NUM!	#NUM!	Sep-22	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R7	The network should be split into Vlans. The firewalls should be deployed.	Network re-design plane is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	Mar-23	Not yet due	Partially complete					#NUM!	#NUM!	Sep-22	Sep-22

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide justification	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon request?	No. of months past agreed deadline	No. of months past revised deadline	Reporting Date	Date Added to Tracker
181951	Structured Assessment 2018		Board Secretary		R2	Standing Orders state the requirement for a Healthcare Professionals' Forum but the Health Board does not have one. The Health Board should establish a Healthcare Professionals' Forum to advise the Board on local strategy and delivery.	Current professionals engagement mechanisms will be reviewed and a Healthcare Professionals Forum be introduced.	Oct-19	Mar-21	Overdue	2	Partially complete		Remains under review - with the approach to stakeholder engagement being formalised.	Delayed in light of COVID-19	Clinical and Stakeholder engagement is undertaken via other means	31-Dec-22		35	18	Sep-22	
181951	Structured Assessment 2018		Board Secretary		R4	The Health Board's internet pages do not provide access to current policies such as the counter fraud policy. The Health Board should update its internet site to provide easy access to current policies and strategies.	The internet and intranet are subject to upgrade and as part of this visibility of policies will be addressed.	Oct-19	Dec-21	Overdue	2	Partially complete		Progress has been made through the introduction of Sharepoint and significant work on the backlog of policy review within the organisation. The Health Board's main policies should now be available on the intranet and when searched for. Further work to be completed in order to close the recommendation fully.	COVID-19 work has taken priority	Corporate Governance Manager undertaking reviews of policy management	31-Dec-22		35	9	Sep-22	
181951	Structured Assessment 2018		Board Secretary		R6	Report cover papers vary in the way in which they are completed which may limit the ability of Board members to focus on the most important areas. The Health Board should improve report cover papers to ensure that they highlight important aspects of reports rather than just describe the content or purpose of the report.	Report cover papers for Board and Board Committees will be reviewed and work undertaken to improve focus on key aspects.	Jun-19	Mar-21	Overdue	3	Partially complete		Report templates are being reviewed as part of establishment of committees for 2022-23 and the development of a number of reporting templates for cyclical reporting and assurance reports.	COVID-19 arrangements have taken priority over this work.		31-Dec-22		39	18	Sep-22	
202152	Structured Assessment 2020		Board Secretary		23	The formal mechanism for consulting with the Stakeholder Reference Group and Healthcare Professionals Group was not utilised as neither group is fully established. Establishing both groups forms part of the Board's Annual Governance Programme, which has been delayed due to COVID19.	•Linked to 2018 & 2019 Structured Assessment actions. To be taken forward in-line with the Board's Annual Governance Programme. This has been delayed in light of the COVID-19 pandemic.	Mar-22		Overdue	2	Partially complete		See R2 above	See R2 above	See R2 above	See R2 above		6		Sep-22	
202152	Structured Assessment 2020		Director of Nursing & Midwifery		41	During the first quarter of 2020-21, the Health Board received 36 formal concerns, which is a reduction on the same period in 2019-20. The reduction is attributed to the COVID-19 pandemic and the temporary closure of a number of services. The concerns raised primarily related to access to services and appointments. The Health Board also received six formal concerns about commissioned services in quarter one. Work is ongoing to improve effective management of concerns as the Health Board has found it difficult to meet the target of responding to 75% of formal concerns within 30 working days.	•Linked to 2019 Structured Assessment actions and update. Improvements to be taken forward in-line with the Clinical Quality Framework Implementation Plan, approved by Experience, Quality & Safety Committee.	Mar-22		Deadline Revised		Partially complete		Paper to Clinical QG Group and EQS next week, shows progress in some areas, and other areas affected by COVID-19. CQFIP up to 2022. Update August 22, Improvement plan in place and refreshed in August 2022, this will be presented to PEQS in September 2022. It is recognised that due to small number of formal concerns maintaining a complianc of 75% compliance will be challenging. It therefor important to recognise when concerns are complex with multiple providers when reviewing compliance. This workplan is a regular agenda item at PEQS.	Paper to Exec Committee identifies enablers and barriers - Jan / Feb 2021. Update August 22, complexities of concerns usually incorporating multiple commissioned services impacts compliance, English Trusts are not bound by PTR regulations.	Implementation overseen by QGG and EQS. Update August 22, maintaining regular communication with those raising the concern.			6		Sep-22	
212252	Structured Assessment 2021		Board Secretary		R1	The Health Board is experiencing a period of significant change within its independent members cohort. Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them. To supplement the national induction programme, the Health Board should develop a local induction training programme as soon as possible to help new independent members ease quickly into their role.	Review and strengthen the induction arrangements for Independent Members to improve early understanding of corporate business. To include: •Background information on establishment of the health board •Good governance and structure of Committees •Board Assurance Framework •Cycle of meetings and Terms of Reference •Roles and responsibilities •Declarations of Interest and Standards of Behaviour •Strategic Plans •Role of Charity Trustees •Means of accessing further information on the Health Board	Mar-22		Overdue	2	Partially complete		Work is nearing completion following consultation with IMs of the material to be made available through induction and an ongoing IM library of important reference materials.		Induction meetings with the Board Secretary, Executive Directors and other senior staff cover the items listed in the management response and independent members have ongoing support available in respect of any areas where training or awareness needs are identified	30-Sep-22		5		Sep-22	
212252	Structured Assessment 2022		Board Secretary		R2	The Health Board does not currently have any associate Board members to assist it in carrying out its functions. Previously the Corporate Director (Children and Adults) from Powys County Council was as associate Board member but has not attended. The Health Board should work with Powys County Council to identify a suitable replacement as soon as possible.	Review and strengthen the induction Interim Board Secretary will engage with Powys County Council's Monitoring Officer to identify a replacement Associate Director.	Mar-22		Overdue	2	Partially complete		Corporate Director (Children and Adults) appointment delayed pending appointment within Powys Council but has been re-energised followig appointmet to the role in the Council - expected to be able to conclude the appointmet by the end of the calender year.		Regular liaison is undertaken with the County Council and more formally through JPB and RPB.	31-Dec-22		5		Sep-22	
212253	Audit of Accounts Report - Charitable Funds and Other Related Charities		Director of Finance, Information and IT		R1	We have recommended to the Charity that a more suitable financial system (ie using an accruals basis) be used in future years to reduce the risk of material misstatements of this nature going forward. The Charity have informed us that they are already in the process of moving to the same financial system as the Health Board, and that the new system will be in place for the preparation of the 2021-22 financial statements.	For the 2021-22 Charity Accounts, the Oracle financials ledger system will be used. This will be further expanded to include ordering and electronic payments to be implemented during the 2022-23 financial year.	Sep-22		Overdue		Partially complete		Work is progressing as planned, testing complete and system is going live from October with furtehr testing of ledger and payments and ordering.	This work is being prioritised for completion.	Governance and control maintained during system implementation	Anticipated end September as planned		0		Sep-22	Jun-22

Executive Committee	Date of Meeting: 15 November 2022
Subject:	**IMPLEMENTATION OF WELSH HEALTH CIRCULARS**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 9 November 2022

PURPOSE:
The purpose of this paper is to provide the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHCs).
RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to discuss the current position, considering those WHCs where no progress has been made.

Approval/Ratification/Decision	Discussion	Information
✘	✔	✔

Welsh Health Circulars

1

Audit, Risk and Assurance Committee
15 November 2022
Agenda Item: 3.7

1/3

211/298

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

EXECUTIVE SUMMARY:

Welsh Health Circulars are received from Welsh Government by the Corporate Governance Team, where they are logged and then distributed to the appropriate Executive Director for action.

An overview of the position as of the 19 October 2022 is as follows:

- For those WHCs received in 2018 there are <u>47 Complete and 1 Partially Complete</u>
- For those WHCs received in 2019 there are <u>37 Complete and 1 Partially Complete</u>
- For those WHCs received in 2020 there are <u>15 Complete and 1 Partially Complete</u>
- For those WHCs received in 2021 there are <u>22 Complete and 2 Partially Complete</u>
- For those WHCs received in 2022 there are 3<u> Complete, 6 Partially Complete, and 9 Not Yet Due</u>
- For those Ministerial Directions received in 2022 there are <u>2 Not Yet Due</u>

  Note: WHCs 2022 017, 2022 018 and 2022 021 are not fully applicable to the services provided by the health board and have been classified as partially complete pending further review by the Medical Director.

Appendix 1 provides the Committee with an overview assessment of current outstanding WHCs and Ministerial Directions, and the progress made to action them.

Appendix 2 provides the Committee with an overview of WHCs actioned since the last reporting period.

Welsh Health Circulars

2

Audit, Risk and Assurance Committee
15 November 2022
Agenda Item: 3.7

2/3

212/298

DETAILED BACKGROUND AND ASSESSMENT:

Previously, work has been taken forward to implement robust systems for recording and tracking WHCs from Welsh Government. The circulars were re-introduced in September 2014 to replace ministerial and health professional letters.

The Health Board has implemented a tracking tool for monitoring the status of WHCs, which reflects the tracking tool also adopted for the monitoring of audit recommendations and regulatory reviews and inspections.

The following table provides an overview of the progress made against the implementation of WHCs received in 2018, 2019, 2020 and 2021.The table also provides an update on the progress made against WHCs received in the 2022 year to date.

	2018		2019		2020		2021		2022	
Not Yet Due	0		0		0		0		9	
No Progress	0		0		0		0		0	
Partially Complete	1		1		1		2		6	
Complete	47		37		15		22		3	
TOTAL NUMBER ISSUED	**48**		**38**		**16**		**24**		**18**	

NEXT STEPS:

The Corporate Governance Team will continue to log and distributable Welsh Health Circulars from Welsh Government to the appropriate Executive Director for action as and when they are received. An updated position will continue to be reported to the Audit, Risk and Assurance Committee on a quarterly basis, the next update report is due to be presented on 31st January 2023.

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Welsh Health Circulars

3

Audit, Risk and Assurance Committee
15 November 2022
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WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2018-022	Sharing Patient information between healthcare professionals – a joint statement from the Royal College of Ophthalmologists and College of Optometrists	03/09/2018	To note that on 20 March 2015 the Royal College of Ophthalmologists and the College of Optometrists issued a joint statement encouraging ophthalmologists to share clinical information with the referring optometrist. To ensure hospital policies and procedures encourage this communication so that it becomes standard practice for planned and unplanned ophthalmology care in Wales.	Medical Director		Partially Complete	March 2022 For Planned Care Powys Provider information is shared with the referrer (optometry/GP) and the patient copied to wider MDT as required. The introduction of the EPR in PTHB will further support this information sharing pilot site due to go live in April 22 with further roll out across in reach ophthalmology throughout 22/23. Clarification of the current situation was sought from localities in September 2018. The north Powys locality confirms the destination of clinic letters is instructed by the consultant. Sending information back to the referrer (as well as the patient's GP) is inconsistent. The locality has agreed to draw the consultants' attention to the requirements of the new WHC. A response from the mid/south Powys locality is still being pursued. Update - The joint statement clarified best practice as writing to the referring optometrist as well as the GP. We can ensure that that is being done in Powys hospitals, but providers out of the county will have their own policies, hence I expect that the picture across Powys is variable. With the new EPR optometrists will be able to look at eye care records for their own patients, including clinic letters, so this will become moot. Of course this will not apply to our English providers.	022- Sharing Patient Information - Royal College of
2019-019	AMR & HCAI IMPROVEMENT GOALS FOR 2019-20	08/07/2019	Health Board staff should be aware of the Improvement goals for HCAI & AMR for 2019-20. The health board will be expected to report on progress at the Quality and Delivery Meetings.	Medical Director		Partially Complete	October 2022 Update HCAI 2021/22 Full Year reduction expectationshave all been met. C. difficile: Rate of 25 per 100,000 - Achieved S. aureus bacteraemia: Rate of 20 per 1000,000 population - Achieved E. coli bacteraemia: Rate of 67 per 1000,000 population - Achieved Klebsiella sp. Bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved P. aeruginosa bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved 8 years since last MRSA bacteraemia. March 2022 See also 2021/028 AMR & HCAI Improvement Goals For 2021-22 for more detailed update 5 year National Action Plan 2019 – 2024 underpinning the UK AMR Strategy 20: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024	019 - HCAI AMR Targets 2019-20 FINAL.pdf
2020-003	Value Based Health Care Programme - Data Requirements	04/03/2020	Continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms; Work with NWIS to enable the flow of audit and PROMs data into NWIS for the purposes of creating visualisations and dashboards for Value Based Health Care approaches.	Medical Director	Immediate	Partially Complete	October 2022 Update. Survey of PTHB services to understand PROMs and PREMs already in use completed. Links made with Welsh Value in Health Centre (WViHC) to national work and contact made with English Integrated Care Systems to discuss PROMs and PREMs for Powys patients treated in England. Discussion with WViHC and DHCW about PROMs for Powys patients treated in other Welsh health boards and in English NHS Trusts suggests dataflows should allow this (may require DHCW approaching NHS Digital). A paper outlining an organisational approach to generic PROMs will be considered by PTHB Transformation & Value Group Executive Committee on 09/11/22. Work is underway in Powys in relation to: •Diabetes •Frailty •Eye Care (Cataracts) •Cancer •MSK (Orthopaedics) PTHB has continued to raise the importance of nationally developed dashboards including commissioner views and including English data for Welsh patients treated over the border to ensure that health boards can understand outcomes, cost and experience for all of their resident populations.	
2021-009	School Entry Hearing Screening pathway	25/03/2021	Health Boards should begin implementation of the new pathway as soon as possible and seek full implementation by April 2022. Welsh Government wish for health boards to follow the recommendations below and be able to provide updates at three monthly intervals from April 2021. Health Boards will be aware that there are two cohorts of children that will need "mopping up" due to the Covid-19 pandemic, communication of how this will be managed will follow with the "Standard Operating Procedure" and related documentation.	Director of Primary, Community and Mental Health	30/07/2022	Partially Complete	17/10/2022 progress continues with communications between audiology and school nurses, screening remains with SNs. Led by the PTHB Head of Audiology, in conjunction with School Nursing service with Powys, this has already progressed some key elements. Expectation of quarterly updates prior to full implementation no later than April 2022.17.06.2022 - Discussions ongoing, Head of Audiology leading, SBAR completed by Head of Audiology with Standard Operating Procedure also in process of being completed by service. Audiology requesting screening remains with School H7 Nursing with their oversight. Discussions planned between Audiology and School Nursing in coming weeks with a view to completing implementation September 2022. School Nursing services have undertaken 'mop up' of outstanding cohorts and programme will be up to date by end July 2022.	J:\ Services\Risk & As
2021-025	Carpal Tunnel Syndrome Pathway	15/09/2021	Health boards will be expected to provide a development plan by 15 November 2021 which outlines the transition to the new CTS Pathway within the 6 months.	Medical Director		Partially Complete	October 2022 Update Followed up with National AHP rep for WOB - other HBs still following existing pathways and no progression of discussions nationally to date. Decision to be made locally whether primary care position has now changed to facilitate implementation of the WOB endorsed CHS pathway in Powys, this could be facilitated through the changes arising from the Accelerated Cluster Development structure. June 2022 Update Still awaiting national discussion. March 2022 Update. Following submission of a development plan for this WHC, an implementation group was formed. Concerns were raised regarding the ability to embed the assessment measure advised within the WHC into primary care at such a busy time operationally and advice was sought from other HBs MSK leads to determine how this was being managed across Wales. Feed back was that there were concerns regarding the pathway and its implementation from most HBs and the AHP representative on the Welsh Orthopaedic Board agreed to take this back to the Board for discussion. Unfortunately, the meeting scheduled for February was postponed to March and has again been postponed to May meaning that it has not yet been discussed. Therefore whilst we have a development plan in place for this WHC, implementation has been paused whilst we await discussion at the WOB in relation to the national feed back.	J:\ Services\Risk & As
2022-007	Recording of Dementia READ codes	15/02/2022	Annex 1 sets out the READ codes which should be captured by memory assessment and GP/ primary care services and recorded on all information shared between services, to the person living with dementia and their carer (if they wish to receive this information), and within the Memory Assessment Service, Learning Disability Memory Assessment Service and primary care data bases. It also sets out guidance for Welsh Health Boards to assist with the recoding of a diagnosis of dementia using the READ CODES.	Director of Primary, Community and Mental Health	30/07/2022	Partially Complete	28.03.22 Circular shared with General Practice. GP already familiar with the READ codes as need to be caputured for QAIF. READ coded dementia registers in place. 30.03.22 The READ codes are included in the Dementia Care Pathway of Standards. The Dementia Lead is working with Improvement Cymru and PTHB MAS teams to ensure READ codes are captured on all correspondence to GP's and copy letters to families in order to capture Powys dementia diagnostic rates. This needs to be in place in order to reflect realistic diagnostic rates. Historically READ codes have not been used on the correspondence but currently work is underway with MAS admin, nurses and consultants to ensure this does happen going forward. 17.06.2022 medical secretaries have confirmed that they are using the new read codes. PTHB has asked to add some other codes too, as sometimes the doctors give a 'probable' diagnosis, Dementia Lead investigating, updated expected July 2022.	WHC 2022 007 - READ codes

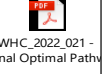|							

2022-005	Data Requirements for Value Based Health Care	24/03/2022	The basis of the WHC and subsequent processing of information is made in consideration of:
			  Section 1 of the National Health Service (Wales) Act 2006 which places a duty on the Welsh Ministers to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales, and in the prevention, diagnosis and treatment of illness. Section 2 of that Act empowers Welsh Ministers to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.
			  Pursuant to Section 3 of the National Health Service (Wales) Act 2006 the Welsh Ministers have a statutory duty to, inter alia, provide throughout Wales, to such extent as they consider necessary to meet all reasonable requirements, healthcare services and such other services or facilities as they require for the diagnosis and treatment of illness.
			  Pursuant to Section 12 of the National Health Service (Wales) Act 2006, the Welsh Ministers may direct a Local Health Board to exercise in relation to its area functions relating to the health service. Pursuant to the Local Health Board (Directed Functions) (Wales) Regulations 2009, the duty under Section 3 of the 2006 Act has been delegated to the Local Health Boards and are thus responsible for the provision of health services in Wales.
			  Pursuant to Section 18 of the National Health Service (Wales) Act 2006, the Welsh Ministers may by order establish NHS trusts to provide goods and services for the purposes of the health service. Pursuant to Section 19 of the National Health Service (Wales) Act 2006, the Welsh Ministers may give directions to an NHS trust about its exercise of any functions. The supply of data to facilitate the work of the Welsh Value in Health Centre and in particular to continue to submit data to UK-wide clinical audit and outcome reviews and national PROMs platforms falls within the statutory functions of the Local Health Boards and the Trusts.
			  Pursuant to Section 22 of the National Health Service (Wales) Act 2006, the Welsh Ministers may by order establish special bodies, known as a Special Health Authorities, for the purpose of exercising any functions which may be conferred on them. Pursuant to Section 24 of the National Health Service (Wales) Act 2006 the Welsh Ministers may direct a Special Health Authority to exercise any of the functions of the Welsh Ministers relating to the health service which are specified in the directions. Section 23 of the National Health Service (Wales) 5 Act 2006 provides that the Welsh Ministers may give directions to a Special Health Authority about its exercise of any functions. The Digital Health and Care Wales (Establishment and Membership) Order 2020 ("the Order") came into force on 30 December 2020 and established Digital Health and Care Wales ("DHCW") as a Special health Authority and made provision about its functions and membership. Article 3 sets out the nature of DHCW's functions which are to be specified more particularly in directions given by the Welsh Ministers under Section 24 of the National Health Service (Wales) Act 2006.
				Director of Finance and IT, Medical Director and Director of PCCMH	31/03/2025 Not Yet Due	Action on going to develop PROM and PREM data within the Health Board and to ensure alighed to WHC requirements, also linking in with Value in Health to align to national approach re PROM and PREM.
						Agreement from VBHC Programme Board on 24.05.2022 to link and track through VBHC Programme Plan.
							WHC 2022 005 requirements for V WHC 2022 005 - requirements for

2022-010	Reimbursable vaccines and eligible cohorts for the 2022/23 NHS seasonal Influenza (flu) Vaccination Programme	29/03/2022	General practices, community pharmacies and health boards/trusts should review influenza vaccine orders in light of this update to attain levels of uptake at least equivalent to those achieved in 2021-22. There may be further policy developments to support maximum uptake across all eligible cohorts during 2022-23. Further advice will be communicated as soon as possible in the Chief Medical Officer's annual influenza letter, which will be issued in the summer.	Director of Public Health	01/03/2023 Not Yet Due	update 17/10/22:- Regular PTHB Influenza Vaccination Oversight Group held, led by Consultant in Public Health, with GP Practice reps. GP and Community pharmacies commissioned to deliver flu vaccine. Correspondence from pharmacy team and Primary care team to community pharamcies and GP Practices week of 03/10/2022 to remind to administer correct vaccine to eligible groups and to inform HB of any errors.	WHC_2022_010 - bursable vaccines

2022-009	Prioritisation of COVID-19 patient episodes by NHS Wales Clinical Coding Departments	14/04/2022	Due to the need for COVID-19 information to be as real-time as possible all NHS Wales Clinical Coding departments are asked to ensure that processes are put in place as soon as possible to ensure the following:
			  All FCEs for patients with COVID-19 are identified upon discharge and prioritised by the Local Health Board/NHS Trust for the assignment of codes
			  Such episodes of care are coded within the first week following discharge to allow for an accurate view of COVID-19 inpatient data on a weekly basis
			  Each Local Health Board and NHS Trust to report their current numbers and percentages of uncoded COVID-19 and non COVID-19 episodes to Welsh Government (HSS.Performance@gov.wales) on the last day of each month
				Director of Finance andf ICT	28/02/2023 Not Yet Due		WHC 2022 009 - vid 19 Priority Clini

2022-014	AMR & HCAI IMPROVEMENT GOALS FOR 2021-23	01/03/2022	Wales remains committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action PlUK AMR Strategy an 2019-24 to combat antimicrobial resistance, through lowering the burden of infections, improving treatments and optimising our use of antimicrobials in humans.. National Action Plan ambitions are shown in highlighted boxes as applicable to each improvement goal.	Director of Nursing and Midwifery	31/03/2023 Not Yet Due		WHC_2022_14 - CAI Improvement
2022-016	The National Influenza Vaccination Programme 2022-23	01/06/2022	Health Boards are asked to take a strategic approach to identify and exploit opportunities for a single programme, including co -administration of Flu and COVID-19 vaccines. This may entail taking key operational decisions, such as ensuring supplies of flu and COVID-19 vaccine are available for co-administration in suitable settings. It is likely that co-administering both the vaccines at the same time will go some way to increase flu vaccine uptake, to a level commensurate with COVID-19 take-up, particularly for younger at risk groups. Flu at risk cohorts have been expanded for 2022-23 to more closely align with COVID at risk groups and maximise opportunities for co-administration.	Director of Public Health	31/03/2023 Not Yet Due	update 17/10/22:- Regular PTHB Influenza Vaccination Oversight Group held, led by Consultant in Public Health, with GP Practice reps. All GP Practices and Community Pharmacies participating in flu vaccination programme. All GP Practices invited to participate in the Autumn covid-19 vaccination programme. 12 out of 16 GP practices agreed to participate in covid-19 campaign: 11 GP Practices offering covid-19 vaccine to over 75s cohort and COPD cohort, 1 GP Practice offeriing to all eligible groups (bar Health & social care staff/care home residents). Delivery of remaining coivd-19 to eligble groups via HB MVC/Mobile teams. Co-administering flu and covid vaccination to health board staff. Meetings held with individual GP Practices in late August/early September to discuss COVID-19 programme delivery and confirmation letter sent to each individual practice outlining programme expectations and support available.	WHC2022-016 - National Influenza

Ref	Title	Date	Description	Lead	Deadline	Status	Update	Link
2022-002	NHS Wales National Clinical Audit and Outcome Review Plan. Annual Rolling Programme for 2022-2023	10/06/2022	Health boards, trusts and relevant special health authorities in Wales are required to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: The Plan details the role each of us has for taking this work forward and includes the list of National Clinical Audits and Outcome Reviews, which all healthcare organisations must fully participate in when they provide the service.	Medical Director, Directors of Primary Care and Director of Therapies and Health Science	01/04/2023	Partially Complete	National Diabetes Foot Care Audit: The Powys Teaching Health Board (PTHB) Podiatry service are participating in the audit this year, and use an audit form to record all foot wounds on patients with diabetes. The data is shared and published nationally. The service is also learning from best practice in other areas and areas with similar demographics, whilst tracking progress across years and benchmarking against neighbouring health board areas. Major Trauma Audit (Trauma Audit and Research Network (TARN)): PTHB participates in the Major Trauma Network Audit - via the South Wales Major Trauma Network (SWMTN). All data is captured and entered in the acute pathway and entered by clinicians and administrators working in acute sites within the network to the TARN database. No PTHB clinicians enter data. TARN data is reported via the South Wales Trauma Network Governance Group on a quarterly basis. PTHB utilised TARN data to inform the SWMTN Peer review process in April 2022 and also feeds back via NC&S Steering Group. Implementation of learning and improvement from the audit is reported through PTHB Stroke and Neurological Conditions Steering Group, which meets quarterly. Sentinel Stroke National Audit Programme (SSNAP): PTHB participates on the non-acute inpatient rehabilitation and six month review sections of SSNAP. Data is collected by clinicians on the two inpatient stroke wards and by clinicians delivering six month reviews and entered either by them directly or by the Community Neuro Service Coordinator from a paper record. The Information Team have developed a dashboard in the Information Focused On-line Reporting (IFOR) system and support the extraction of the anonymised data from SSNAP to allow for monthly submissions to the Delivery Unit for performance management. Quarterly reports are submitted to the S&NC SG. The data is reviewed regularly by clinical teams, service managers and S&NC SG to inform service improvement, changes to workforce and service evaluation. All Wales Audiology Audit: Every year, Wales Audiology departments, including PTHB's, take part in a national audit. 2021 was paediatric service, 2022 is adult rehabilitation service and 2023 will be tinnitus service. Following the audit, the report is sent to Audiology HOS and execs. Audiology are required to make the report available to the public, so the PTHB Audiology service publish this on the internet for patients to see and on the PTHB intranet for staff to see. The most recent PTHB paediatric and adult Audiology audits are published on the PTHB Audiology internet pages. Following each report the Audiology department write an action plan of any changes or improvements. The report and action plan is discussed in the heads of therapies meeting and the audit feedback group – the 2020 paediatric audit was presented in the women and childrens health feedback group. In addition to being audited, the PTHB Audiology service also audit another department, to observe and learn other ways of working. National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation Audit: PTHB participated in the 2019 audit but did not participate in the most recent audit in 2021 due to not delivering pulmonary rehabilitation at that point because of the Covid-19 pandemic. PTHB has re-established its pulmonary rehabilitation offer and intends to continue to participate in future audits. The audit provides a useful benchmark of services, and is supported via governance through PTHB's Breathe Well Transformation Programme as part of wider respiratory transformation work. PTHB has submitted data previously and as far as we are aware, no issues around data sharing have been identified. PTHB has used the learning from the audit to help the development of its pulmonary rehabilitation services, such as to conduct initial and discharge assessments for home-based pulmonary rehabilitation programmes, and to provide clinical leads with designated sessional time to coordinate and manage / develop the service.	WHC2022 002 - onal Clinical Audit
1MD	Our programme for transforming and modernising planned care and reducing waiting lists in	26/04/2022	This plan sets out a number of clear priorities for action over the next four years. They focus on immediate actions to release capacity to enable the NHS to see and treat more people and some slightly longer-term actions which will continue to transform the service, in line with the vision set out in A Healthier Wales.	Director of Primary, community Care & Mental Health	Apr-26	Not Yet Due		MD1. ng and Modernisin
2022-019	Non Specialised Paediatric Orthopaedic Services	21/06/2022	To ensure that this service specification is used to inform the delivery and commissioning of Non Specialised Paediatric Orthopaedic Services for children (aged up to 16 years) resident in Wales.	Director of Primary Care, Community & Mental Health Services and Senior Manager Planned Care	01/04/2025	Not Yet Due		WHC 2022 019 - Specialised Paedi
2022-012	Donation and Transplantation Plan for Wales 2022-2026	16/06/2022	Health Boards and NHS Trusts, where appropriate, are expected to work with the Welsh Health Specialised Services Committee (WHSSC), Welsh Renal Clinical Network (WRCN), NHS Blood and Transplant (NHSBT), Welsh Transplantation Advisory Group (WTAG), third sector and other relevant organisations towards implementing the Donation and Transplantation Plan for Wales. Health boards should take account of the priorities for donation and transplantation when planning their services and developing their Integrated Medium Term Plans (IMTPs).	Medical Director	31/12/2026	Not Yet Due		2022- tion-and-transplan
2022 018	Guidelines for managing patients on the suspected cancer pathway	30/06/2022	The achievement of the cancer target is the responsibility of NHS Wales as set out in the quality statement for cancer. The underlying principle of the suspected cancer pathway is that patients should receive excellent care without delay. This document sets out the rules to ensure that each patient's pathway waiting time is consistent and unnecessary delay does not occur as patients pass between clinical teams and organisations.	Medical Director	Immediate	Partially Complete	October 2022 Update PTHB provides limited diagnostic services for cancer and does not provide any cancer treatments. Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. The Cancer Renewal Programme has establised a Harm Review Panel to review on breach reports and pathway reviews completed by Commissioned Providers to identify factors causing delays to inform future planning of services and commissioning to follow up. A Cancer Tracker role has been created as part of this process. PTHB is also developing a Power BI Tool to enable live tracking of Powys residents on urgent suspected cancer pathways to identify patients who are at risk of breaching and who are breaching target waiting times to enable intervention. This process is in development.	2022- 018 nes-for-managing-
2022 006	Direct Paramedic referral to same day emergency care	21/04/2022	In order to reflect local service models, each health board will need to agree with WAST the mechanisms for enabling the 'clinician to clinician' discussion, which forms the basis of the acceptance of patients into SDEC services.	Director of Primary, Community Care and Mental Health	Immediate	Partially Complete	17/10/2022 Emergency/acute care not commissioned within Powys. However, IMTP work with WAST, OOH and internal suppliers to determine capacity for physician triage of WAST stacked calls underway. Scoping exercise underway with intention for implementation in readiness for winter pressures and inclement weather end Q3/beginning Q4. Ongoing work with commissioned partners to ensure quality, safe and timely care in Emergency Departments – annual cycle	2022-006-Direct-p medic-referral-to-s
2022 017	Wales Rare Diseases Action plan 2022-2026	16/06/2022	Health boards and NHS trusts, where appropriate, are asked to work with Welsh Health Specialised Services Committee (WHSSC), Rare Disease Implementation Group (RDIG), third sector and other relevant organisations to facilitate and implement the priorities and actions outlined in the Wales Rare Disease Action Plan. Health boards should take account of the priorities for rare diseases when planning their services and developing their Integrated Medium-Term Plans (IMTPs).	Medical Director	Ongoing	Partially Complete	October 2022 Update PTHB does not provide any specialised services. It does not have the range of Clinical Directorates that would usually be involved in supporting and implementing this work in relation to Rare Diseases. The Planning and Performance Directorate attends the WHSSC Management Committee and the CEO attends the WHSSC Joint Committee. Through participation in the WHSSC Management Group and Joint Committee PTHB works to ensure that its Integrated Medium Term Plan reflects the approved WHSSC Integrated Commissioning Plan. PTHB does not have the capacity to take forward this work in a more detailed way. The health board is attempting to create a Specialised Pathway Lead post.	2022-017 - Wales e Diseases Action

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2022 022	Role of the Community Dental Service and Services for vulnerable people	22/08/2022	Health boards should use their professional advisory structures to review and inform the provision of dental care by all local dental services including the CDS, primary care services provided by General Dental Services (GDS), Personal Dental Services (PDS) and Hospital Dental Services (HDS), and how these relate to local authority boundaries and primary care clusters. Specialists and Consultants in Dental Public Health will provide detailed and expert assistance in needs assessment and in collaboration with others, advice on service development. The Community Dental Service should be regarded as an integrated dental service with a diverse and flexible role. It should not be regarded as a purely primary care-based service. A strong community dental service will provide all services needed for its local population and this can include both consultant, specialist, intermediate and routine general dental services. The Community Dental Service should be encouraged to work in collaboration with local hospital based dental services including oral and maxillofacial services. An effective CDS will require investment in both workforce and infrastructure, ensuring that the clinicians have access to modern equipment and robust IT systems. Poor infrastructure is seen as a barrier to recruitment and retention of staff.	Director of Primary, Community Care and Mental Health	01/08/2024	Not Yet Due		WHC 2022 022 - Role of the Commu
2022 021	National Optimal Pathways for Cancer	28/07/2022	The Quality Statement for Cancer requires that the nationally optimised pathways are fully embedded in local service delivery. They are designed to reduce unwarranted variation in care delivery across Wales and to help organisations to plan to meet the Suspected Cancer Pathway waiting time target. Executive Board note and discuss the pathways as part of the implementation of the Suspected Cancer Pathway. Executive leads for cancer use the pathways to support the planning, delivery, and performance monitoring of cancer services. Directors of Planning incorporate the pathways into their planning assumptions. Site specific local, regional and national MDTs to adopt the pathways or justify reasons for variations.	Medical Director	30/09/2022	Partially Complete	October 2022 Update PTHB provides limited diagnostic services for cancer and does not provide any cancer treatments. Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. PTHB has established a Harm Review process to review breach reports produced by the commissioned providers. PTHB is engaging with the Wales Cancer Network (WCN) programme to review USC pathways for Powys residents. The Improving the Cancer Journey (ICJ) Programme in Powys is offering eHNAs to people diagnosed with cancer to provide support and facilitate accessing local resources to meet their needs. The PTHB Advice, Support and Prehabilitation Programme are exploring Prehabilitation in collaboration with the ICJ Programme for people living with cancer in Powys.	WHC_2022_021 - onal Optimal Path
2MD	Financial Entitlements Amendments	08/06/2022	All existing patient facing staff to undertake the national care navigation training package and all new patient facing staff complete the national care navigation training package within 3 months of start date [if virtual course is available from HEIW]. Practices will supply names of new starters and date of training undertaken. 2. Appointments are available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. (Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again). 3. To maintain a planned and forward looking approach to consultations, practices must undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable.	Director of Finance and IT		Not Yet Due		3Ministerial-Direc on- Financial-entit
2022-023	Changes to the vaccine for the HPV immunisation programme	09/09/2022	Change to the vaccine schedule The Gardasil®9 vaccine will be provided for the following schedules of the HPV programme: • a one-dose schedule for the routine adolescent programme and MSM programme before the 25th birthday • a 2-dose schedule from the age of 25 in the MSM programme • a 3-dose schedule for individuals who are immunosuppressed and those known to be HIV-positive The UK Health Security Agency will continue to supply vaccine for the HPV programme in the usual way. It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year. Until the one dose schedule commences, the current 2 dose schedule will remain in place. Further communications will be issued once decisions have been made on the timing of the changes.	Director of Public Health	30/09/2024	Not Yet Due	Update 17/10/2022: email sent 13/09/2022 from DPH to school health nursing (immunsation service leads)and Chief Pharmacist to inform of future changes and to action. Confirmation received from chief pharmacist is aware for PGD changes. No further action to take currently as the WHC states: 'It is important to note that we do not expect the one dose schedule to commence before the 2023/24 academic year'.	2022_023-WHC-H nunisation Progran

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WHC No.	Name of WHC	Date Issued	Overarching Actions Required	Lead Executive	Expected Date of Completion	Status	Comments	WHC
2019-034	National Optimal Pathways for Cancer (2019 tranche 1)	02/10/2019	Executive Board note and discuss the NOPs as part of the implementation of the single cancer pathway. Executive leads for cancer use the NOPs to support the planning, delivery and performance monitoring of cancer services. Directors of Planning incorporate NOPs into their planning assumptions, recognising that they won't all be immediately achievable but should be worked towards in the medium term. Site specific local, regional and national MDTs to adopt the NOPs or justify reasons for local and limited variations	Medical Director		Complete	**March 2022** A key renewal priority of PTHB is cancer services. A Renewal Cancer Transformation Programme Board has been established, chaired by the Medical Director. The priorities for the Programme Board have been agreed by PTHB and the Executive Committee as set out in the PTHB Annual Plan. This includes work in relation to the Optimal Pathways. A Project Manager and project support officer have been funded and employed by the Welsh Cancer Network to work with PTHB to review compliance with the nationally agreed Optimal Pathways for Powys residents. This is a particularly complex issue for PTHB as it has no DGH level services and half of its patient flows involve providers in England. The initial priority will be the GI pathways. A Harm Review Panel has been established to review breach reports and pathway reviews completed by provider organisations for Powys patients on cancer pathways. A cancer tracker has been employed to monitor available data and coordinate the Harm Review Panel activity. A Business Intelligence Tool is currently being developed to enable live tracking of Powys patients on Cancer Pathways. **Please note that WHC 2022-021 superseeds this WHC and therefore has been closed.**	034 - Cancer - Policy - Single Cancer Pathway -
2020-014	Ear Wax Management	29/09/2020	Determine and report on current service provision across Wales. Develop a national integrated pathway for the safe and effective management of ear wax to provide consistent patient outcomes across Wales and ensure: Equitable access; Efficient and effective use of NHS resources; cost effective and prudent; Consistent seamless management across primary, community and secondary care settings; Self-management where clinically appropriate, empowering people to better manage their own care; Compliance with NICE guidance and Audiology Quality Standards. https://gov.wales/sites/default/files/publications/2019-10/quality-standards-foradults-hearing-services-the-assessment-and-audit-tool.pdf	Director of Primary, Community and Mental Health		Complete	17/10/2022 implemented a powys-wide, audiology-led wax removal service on 1st April 2022. Business Case for the model had been approved by Executive Committee. Model wil now be recruited to and implemented. Likely service will not be in place until late in Q4 2021/22. WG have been informed of this progress and position. Paper due into executives during June 2021.	J:\ Services\Risk & As
2021-021	Introduction of Shingrix® for Immunocompromised Individuals (From September 2021)	27/08/2021	From 01 September 2021, general practices should offer the non-live shingles vaccine Shingrix® to all those who are eligible for shingles vaccination but are clinically contraindicated to receive the live vaccine Zostavax® due to their immunocompromised status. In line with the current requirements of the shingles programme, the vaccine should be offered to those becoming eligible at 70 years old and to unvaccinated individuals in their 70s who have not yet reached their 80th birthday.	Director of Public Health	15/10/2021	Complete	Circular was sent to primary care by WG. Medicines Management have confirmed that PGD for Shngrix is in place. Awaiting confirmation from PTHB Primary Care that there are no changes required to existing service agreements with primary care. Vaccine routinely offered as par of primary care contract with GP Practices. No further actions required. 25/03/22: Primary care asked to contact practices to gain assurance that eligible patients are being called in for their vaccinations.	J:\ Services\Risk & As
2021-022	Publication of the Quality and Safety Framework	17/09/2021	Can you please share this Framework, link attached below, with all health and care staff within your organisations and continue to embed the ethos of good quality, safe care above all else.	Director of Nursing and Midwifery		Complete	Met on 27 September 2021 about this and a paper would be presented to the Executive Committee Mid October 2021. Claire Roche (new DoNM) commenced in post 7.3 22. Advised a paper was with Exec colleagues to be completed. CR will liaise with colleagues to understand what further action is required. This framework will be shared via our Learning Group and our Incident Review Group as well as with Operational Groups. The framework will be fundamental to the work that the Organisation is (and will continue to undertake) in relation to embedding the Duty of Quality as part of the Quality and Engagement Act. This action can be closed as as it can be considered to ahve been shared and future work will be about ensuring it is fundamental to our quality and clinically led services.	J:\ Services\Risk & As

2022-015	Changes to the vaccine for the HPV Immunisation Programme	25/05/2022	Forthcoming changes to the human papillomavirus (HPV) immunisation programme. The vaccine supplied for the programme will change from Gardasil® to Gardasil®9 during the 2022/23 academic year. The UK Health Security Agency will continue to supply vaccine for the HPV programme in the usual way and will issue the remaining central supplies of Gardasil® before the switch to Gardasil®9, which will occur in the second quarter of 2022.	Director of Public Health	30/06/2022	Complete	Please note that this WHC has been superseeded by WHC 2022-023	WHC 2022 015 - nges to the vaccine
2022 020	Never Events Policy and Incident list	22/07/2022	As with all patient safety incident reporting NHS organisations must assure their Boards that Never Events have been investigated appropriately, in line with the national reporting policy and appropriate actions taken with any lessons learnt shared throughout the organisation to help reduce the risk of similar Never Events happening again. Robust monitoring processes should be in place to support implementation and delivery of agreed actions and to ensure sustainability of those actions going forward. As part of quality assurance processes the NHS Wales Delivery Unit will monitor and review all Never Events, including lessons learnt and the timely implementation of corrective actions. Where appropriate the NHS Wales Delivery Unit will engage with individual organisations to provide support and, or escalate any unresolved matters through existing escalation frameworks.	Director of Nursing and Midwifery	Immedidate	Complete	The Never events process is embedded and in place. This forms part of our NRI structure.	WHC-2022-020-n events-policy-july

AUDIT, RISK AND ASSURANCE COMMITTEE	Date of Meeting: 15 November 2022
Subject:	**RISK MANAGEMENT FRAMEWORK**
Approved and Presented by:	Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee, 9 November 2022

PURPOSE:
The purpose of this paper is to provide the Audit, Risk and Assurance Committee with the following documents for discussion, ahead of presentation to the Board for approval: - • revised Risk Management Framework; and • revised Risk Appetite Statement.

RECOMMENDATION(S):
It is recommended that the Audit, Risk and Assurance Committee: • REVIEWS the Risk Management Framework included at **Appendix 1**, ensuring that it remains an effective Framework supporting the organisation's risk management arrangements; and • REVIEWS the Risk Appetite Statement included at **Appendix 2** and provides feedback as part of consultation with Board members prior to submission to Board for approval.

Approval/Ratification/Decision	Discussion	Information
✘	✔	✘

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

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

EXECUTIVE SUMMARY:

The Board is committed to using a systematic and holistic approach to risk management and ensuring that effective risk management is an integral part of everyday management practices across the organisation.

This paper provides the Executive Committee with the:
- revised Risk Management Framework; and
- revised Risk Appetite Statement.

BACKGROUND AND ASSESSMENT:

Risk Management Framework
The Board approved its Risk Management Framework (RMF) in November 2021, which sets out the components that provide the foundation and organisational arrangements for supporting risk management processes across the organisation. The RMF identifies those individuals with responsibilities for the management of risk and sets out the health board's key risk management structures and processes.

The RMF is subject to annual review in order to ensure it fully reflects current arrangements for risk management processes across the organisation and remains fit for purpose. A Risk Management Toolkit has been developed, which provides guidance and templates to support services to actively manage their risks.

The revised RMF and supporting Toolkit will support a robust risk management culture across the health board, by setting out the approach and mechanisms by which the health board will: -

- Ensure that the principles, processes and procedures for risk management are consistent across the health board, and are fit for purpose;
- Ensure risks are identified and managed through robust risk management processes;
- Establish local risk reporting procedures to ensure an effective integrated risk management process across the health board's activities;
- Ensure strategic and operational decisions are informed by an understanding of risks and their likely impact;
- Ensure risks to the delivery of the health board's strategic objectives are eliminated, transferred or proactively managed;
- Manage the clinical and non-clinical risks facing the health board in a co-ordinated way; and
- Ensure the Board and its Committees are suitably informed of the significant risks facing the health board, and the associated plans in place to treat those risks.

The RMF will help build and sustain an organisational culture that encourages appropriate risk taking, to continuously improve the quality of the services provided and commissioned by the health board.

Following review, no fundamental changes to the Risk Management Framework are proposed. The revised Risk Management Framework is attached to this report as **Appendix 1**. For ease of reference, updates to the previous version are included within the document in red font.

Risk Appetite Statement
The Risk Appetite Statement (**Appendix 2**), sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a 'live' document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives or its capacity to manage risk are properly reflected. The Risk Appetite Statement is composed of two parts: a general written statement, supported by the cumulative risk appetite categories.

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

The Risk Appetite Statement for 2021/22 was developed to reflect an increased appetite in relation to innovative and financial risks, which may be necessary to support achievement of the Board's ten-year strategy, 'A Healthy, Caring Powys'. In recognising the risks inherent in healthcare services, the proposed risk appetite statement starts at the basis of a low appetite. The Board's previous Statement stated that the Board had no appetite in a number of areas.

The proposed revised Statement recognises the changing nature of the external environment the health board operates in and the need for greater clarity and granularity to aid decision making and the treatment of risk. As for the RMF, changes from the existing Statement are shown in red text.

NEXT STEPS:

Subject to review by the Audit, Risk and Assurance Committee the revised Risk Management Framework and Risk Appetite Statement will also be presented to the Board on 30 November 2022. Upon approval by Board, Risk Management Framework and Risk Appetite Statement will be published to the organisation.

Risk Management

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Audit, Risk and Assurance Committee
15 November 2021
Agenda item: 3.8

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RISK APPETITE STATEMENT – NOVEMBER 2021

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

The Board places fundamental importance on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy: '*A Healthy, Caring Powys'*.

The health board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.

The Board has adopted the following Risk Appetite Matrix:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.

Risk Appetite	Description
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Board has greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The health board's risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives. The health board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

Risk Category	Description
APPETITE FOR RISK: Minimal	
Safety	We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of, incidents of avoidable harm to our patients or staff. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.
APPETITE FOR RISK: Cautious	
Quality	The provision of high-quality services is of the utmost importance for the health board. The Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a low appetite for risks which my compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact on quality could adversely affect outcomes and experiences of our patients, service users and communities.

Risk Category	Description
Regulation & Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours Framework, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.
Performance and Service Sustainability	We have a low-moderate risk appetite for risks which may affect our performance and service sustainability. We are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19, workforce availability and limited resources) which may result in lower performance levels and unsustainable service delivery for a short period of time.
Financial Sustainability	We have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.
Workforce	The Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. We have a moderate risk appetite for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a high level of risk on some occasions to support patients.

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Risk Category	Description
APPETITE FOR RISK: Open	
Partnerships	The health board is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a high risk appetite for partnerships which may support and benefit the patients in our care. For example, the health board has a high appetite for risks associated with innovation and partnership with industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the health board will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.
APPETITE FOR RISK: Open	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Medium Term Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

This Statement will be regularly reviewed and modified so that any changes to the organisation's strategy, objectives or our capacity to manage risk are properly reflected. It will be communicated throughout the organisation in order to embed sound risk management and to ensure risks are properly identified and managed.

RISK MANAGEMENT FRAMEWORK
NOVEMBER 2022

Document Number:	CGP005	Classification	Corporate

Version No:	Approved by:	Date of Approval:	Date of Issue:	Review Date:
V4.0	Board	November 2021	November 2021	November 2022

Brief Summary of Document:	This document aims to set out the components that provide the foundation and organisational arrangements for supporting risk management processes in Powys Teaching Health Board.

Scope:	This framework applies to Board members; all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of services. Managers at all levels within the health board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the health board.

To be read in conjunction with:	• PTHB Assurance Principles • PTHB Strategic Commissioning Framework & Commissioning Assurance Framework • Health & Safety Policies

Owning Committee	Audit, Risk & Assurance Committee

Document Owner:	Board Secretary	Document Author:	Head of Risk & Assurance

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
2.2	2017 Version Updated to reflect changes in risk management arrangements and organisational realignment	September 2019
3.0	2019 Version Updated to reflect changes in risk management arrangements and organisational realignment	November 2021
4.0	2021 Version Updated to reflect changes in risk management arrangements and organisational realignment	November 2022

Glossary of terms	
Term	Definition
Risk	The effect of uncertainty on objectives. An effect may be positive, negative, or a deviation from the expected. In addition, a risk is often described as an event; a change in circumstance; or, a consequence.
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks, with a view to increasing the probability of success and reducing the likelihood of failure.
Risk management framework	Set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation.
Risk assessment	A systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).
Risk treatment	The development, selection and implementation of risk treatment strategies and controls.
Risk appetite	The amount of risk that an organisation is willing to pursue or retain.
Risk tolerance	The organisation's readiness to bear a risk after risk treatment, in order to achieve its objectives.
Risk owner	The person with the authority and accountability to make the decision to treat, or not to treat the risk.
Strategic risks	Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder.

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Operational risks	Risks that are by-products of the day-to-day running of the Health Board and include a broad spectrum of risks including clinical risk; financial risk (including fraud); legal risks (arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc. Operational risks are managed by the department or directorate which is responsible for delivering services.

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CONTENTS

1.   The Board's Statement

The Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal controls.

The Board is committed to having a risk management culture that underpins and supports the business of the health board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements; meeting objectives; and, promoting its values.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

- Ensuring a dynamic approach to strategic risk management to support achievement of the health board's vision, aims, and strategic objectives;
- Promoting considered risk taking, within authorised and defined limits in-line with the Board's Appetite for Risk (see Risk Appetite Statement at Appendix A);
- Adopting an integrated approach to risk management that includes risks related to clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;
- Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;
- Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and appropriately managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;
- Fostering an organisational culture of openness and willingness to report risks, incidents and near misses that is used for organisation-wide learning;
- Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and
- Providing appropriate training to staff to ensure effective implementation of risk management arrangements.

2. Purpose of the Risk Management Framework

This document sets out the Health Board's vision for managing risk. Through the management of risk, the Health Board seeks to minimise, although not necessarily eliminate, threats, and maximise opportunities.

The Framework seeks to ensure:
- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;

- that the wellbeing of patients, staff and visitors is optimised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

3. Scope of the Risk Management Framework

This Framework applies to Board members; all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Powys Teaching Health Board business. It applies to all activities of the health board, including those related to the commissioning of services.

Managers at all levels within the health board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the health board.

4. The Board's Appetite for Risk

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which the health board operates.

The Board has greatest appetite to pursue innovation, and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The Board's Risk Appetite Statement, which is included at Appendix A, sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified, so that any changes to the organisation's strategy, objectives, or, its capacity to manage risk, are properly reflected.
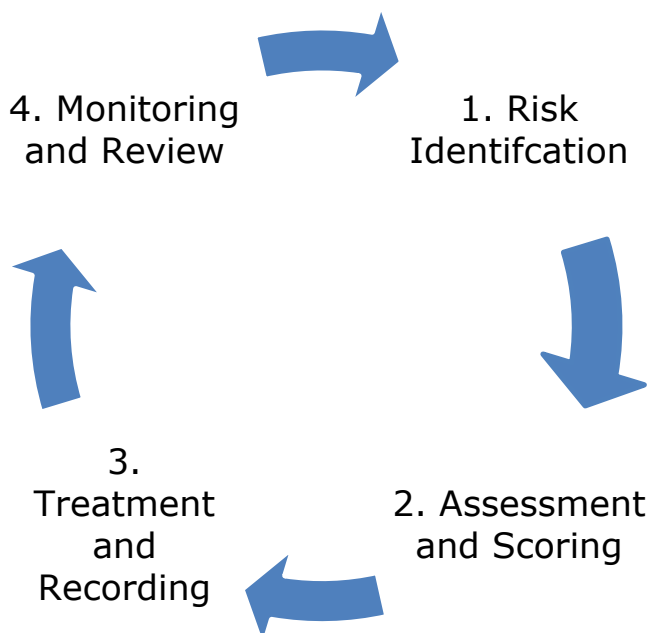
5. The Risk Management Process

Risk Management is the systematic application of management policies, practices and procedures to the task of identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

4. Monitoring and Review

1. Risk Identifcation

3. Treatment and Recording

2. Assessment and Scoring

1. Risk Identification

The health board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care.

2. Assessment and Scoring

Assessment and scoring of risk are used to determine the level of risk, using the health board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. Treatment and Recording

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a risk

register, which is a formal record of the risks that the health board has identified.

4. Monitoring and Review

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

The health board's detailed guidance in support of the risk management process is included in the risk management toolkit on the staff intranet and includes guidelines to Identify, Assess, Treat and Monitor risks.

6.   Levels of Risk

The Risk Management Framework defines three levels of risk:

1. **Strategic Risks** – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.

2. **Operational Risks** – Risks that arise as a result of the day-to-day running of the health board and include a broad spectrum of risks comprising clinical risk (e.g. arising from incidents and complaints), financial risk (including fraud); legal risks (e.g. arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.

3. **Project Risks** – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

Powys Teaching Health Board is predominantly a commissioning organisation, buying services on behalf of the population from a wide range of providers including primary care contractors; independent sector care homes; ambulance services; district general hospitals; and, other specialist hospitals. The health board's **Integrated Performance Framework** helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients. Through this process, risks may be identified for recording in local or directorate risk registers or the Corporate Risk Register, dependent upon the level and type of risk.

7.   Risk Recording and Escalation

A risk register is a management tool that provides a comprehensive and dynamic understanding of an organisation's risk profile. Effectively used, a risk register will not only drive risk management but should be used to inform decision-making processes. Risk registers are also used to provide assurance that risks are being managed appropriately and effectively.

Recording of Strategic Risk

Strategic risks are recorded in the Board's Corporate Risk Register. The Corporate Risk Register provides an organisational-wide summary of significant risks that have been in the main escalated from Directorate Risk Registers. The criteria for a risk to be included in the Corporate Risk register are:

- The risk must represent an issue that has the potential to hinder achievement of one or more of the health board's strategic objectives;
- The risk cannot be addressed at directorate level;
- Further control measures are needed to reduce or eliminate the risk;
- A considerable input of resource is needed to treat the risk (finance, people, time, etc).

The risks contained in the Corporate Risk Register are aligned to the Board Assurance Framework. The Board Assurance Framework provides a structure and process that enables the health board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic and annual objectives. It ensures that the assurance mechanisms operating across the health board are fully aligned to support the Chief Executive as the Accountable Officer, and the Board, to deliver the organisation's objectives. Further detail on the Board Assurance Framework is provided in the **Assurance Principles Document**.

The Corporate Risk register and Board Assurance Framework are reviewed by the Executive Committee in advance of presentation to the Board at each of its meetings.
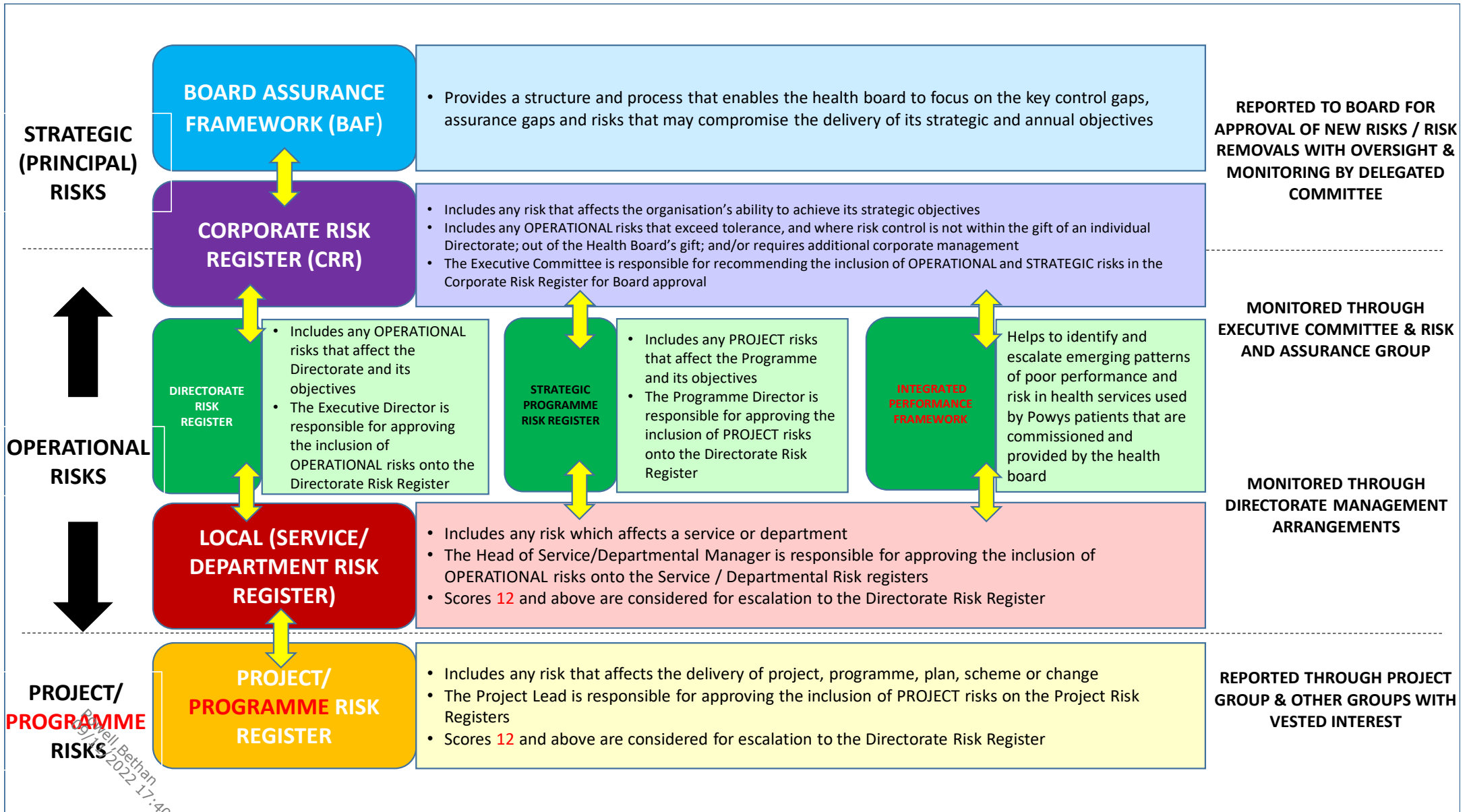
Recording of Operational Risk

Operational risks, where they cannot be immediately addressed, are managed by the department or directorate that is responsible for delivering services, and are captured in local risk registers. If risks cannot be managed to a level that is acceptable at a local level, they are escalated to the relevant Directorate Risk Register. Each Directorate will maintain a comprehensive Directorate Risk Register, which will be informed by relevant local Risk Registers, and is formally reviewed at an appropriate Directorate meeting.

The Risk and Assurance Group will review Directorate Risk Registers bi-monthly to: consider risks that remain at a score of 12 or above after action to treat the risk is taken; and, highlight any new and emerging risks and present action plans for minimising and managing these risks. The Risk and Assurance Group will make recommendations to the Executive Committee on any risks that should be considered for inclusion in the Corporate Risk Register.

The hierarchy of risk registers used in the health board and the relationship between strategic and operational risks is provided below:

STRATEGIC (PRINCIPAL) RISKS

BOARD ASSURANCE FRAMEWORK (BAF)
- Provides a structure and process that enables the health board to focus on the key control gaps, assurance gaps and risks that may compromise the delivery of its strategic and annual objectives

CORPORATE RISK REGISTER (CRR)
- Includes any risk that affects the organisation's ability to achieve its strategic objectives
- Includes any OPERATIONAL risks that exceed tolerance, and where risk control is not within the gift of an individual Directorate; out of the Health Board's gift; and/or requires additional corporate management
- The Executive Committee is responsible for recommending the inclusion of OPERATIONAL and STRATEGIC risks in the Corporate Risk Register for Board approval

REPORTED TO BOARD FOR APPROVAL OF NEW RISKS / RISK REMOVALS WITH OVERSIGHT & MONITORING BY DELEGATED COMMITTEE

OPERATIONAL RISKS

DIRECTORATE RISK REGISTER
- Includes any OPERATIONAL risks that affect the Directorate and its objectives
- The Executive Director is responsible for approving the inclusion of OPERATIONAL risks onto the Directorate Risk Register

STRATEGIC PROGRAMME RISK REGISTER
- Includes any PROJECT risks that affect the Programme and its objectives
- The Programme Director is responsible for approving the inclusion of PROJECT risks onto the Directorate Risk Register

INTEGRATED PERFORMANCE FRAMEWORK
- Helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients that are commissioned and provided by the health board

MONITORED THROUGH EXECUTIVE COMMITTEE & RISK AND ASSURANCE GROUP

LOCAL (SERVICE/ DEPARTMENT RISK REGISTER)
- Includes any risk which affects a service or department
- The Head of Service/Departmental Manager is responsible for approving the inclusion of OPERATIONAL risks onto the Service / Departmental Risk registers
- Scores 12 and above are considered for escalation to the Directorate Risk Register

MONITORED THROUGH DIRECTORATE MANAGEMENT ARRANGEMENTS

PROJECT/ PROGRAMME RISKS

PROJECT/ PROGRAMME RISK REGISTER
- Includes any risk that affects the delivery of project, programme, plan, scheme or change
- The Project Lead is responsible for approving the inclusion of PROJECT risks on the Project Risk Registers
- Scores 12 and above are considered for escalation to the Directorate Risk Register

REPORTED THROUGH PROJECT GROUP & OTHER GROUPS WITH VESTED INTEREST

8.1 The Board

The Board (Executive Directors and Independent Members) have collective responsibility for the setting and ensuring delivery of strategic objectives. Key strategic risks are identified and monitored by the Board. The BAF and CRR provide a central record of risks to the delivery of its strategic objectives. It is the duty of the Board to discuss and advise on the format and content of the BAF. It is also the duty of the Board to appropriately monitor Powys THB's significant risks, associated controls and assurances.

The Board is also responsible for ensuring that the health board consistently follows the principles of good governance; ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driving the delivery of the health board's strategic objectives. This is the meaning of 'assurance' and is a fundamental principle of good management and accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk.

In the context of this Framework the Board will:
- demonstrate its continuing commitment to risk management through the endorsement of this Framework;
- ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
- take a lead role in 'horizon scanning' for emerging threats/risks to the delivery of the health board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
- oversee and participate in the risk assurance process;
- ensure communication with partner organisations on problems of mutual concern including risks;
- ensure that appropriate structures are in place to implement effective risk management;
- commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
- ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data; and
- receive reports from the committees of the Board in line with terms of reference and workplans of those committees.

The Terms of Reference for the Committees that report to the Board are included on the health board's website:
Powys Teaching Health Board Committees - Powys Teaching Health Board (nhs.wales)

8.2 Individual Responsibilities

All members of staff, and those working on behalf of the health board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework.

The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

Chief Executive Officer (CEO)

The CEO is the Accountable Officer of the health board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance. The CEO has overall accountability and responsibility for:
- ensuring the health board maintains an up-to-date Risk Management Framework endorsed by the Board;
- promoting a risk management culture throughout the health board;
- ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Board Secretary

The Board Secretary is the delegated lead for risk management in the health board, and is accountable for leading on the design, development and implementation of the integrated Board Assurance Framework and Risk Management Framework. The Board Secretary will:
- lead the embedding of an effective risk management culture throughout the health board;
- work closely with the Chair; Chief Executive; Chair of the Audit, Risk and Assurance Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a health board basis;
- lead the development of, and Chair, the Risk and Assurance Group (established by the Executive Committee);

- work closely with the Chief Executive and Executive Directors to support the development and maintenance of Corporate and Directorate level risk registers;
- develop and oversee the effective execution of the health board's Assurance Framework;
- develop and implement the health board's Risk Management Framework; and
- produce the health board's Annual Governance Statement.

Head of Risk and Assurance

The Head of Risk and Assurance is accountable to the Board Secretary, and in relation to risk management will specifically:

- provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;
- ensure a central system is in place to collate risk registers across the health board, which link to the health board's Assurance Framework;
- support the management and development of the health board's Assurance Framework and Risk Management Framework;
- work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;
- compile the Corporate Risk Register and Board Assurance Framework, for Executive Committee and Board;
- support the development and functioning of the Risk and Assurance Group; and
- provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the Assurance Framework of the organisation.

Executive Directors

Executive Directors are accountable and responsible for ensuring that their respective directorates are implementing this Framework, and related policies/procedures. Each Director is accountable for the delivery of their particular area of responsibility, and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives.

Specifically, they will:
- lead the embedding of an effective risk management culture throughout the health board;
- communicate to their directorate, the Board's strategic objectives; and, ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area, which will encourage integration of risk management;

- co-ordinate the risk management processes which include: risk assessments; incident reporting; the investigation of incidents/near misses; and, the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area, and that risks are treated as required;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post, and that those key objectives are reflected in the individual performance review/staff appraisal process.

In addition, **Clinical Executive Directors** (Medical Director, Director of Nursing & Midwifery, Director of Therapies & Health Sciences, and the Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

Independent Members

Independent Members have an important role in risk management. This role is restricted to seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to Executive Directors and senior management. The role of Independent Members is not to manage individual risks, but to understand and question risk on an informed and ongoing basis.

Additionally, Independent Members chair Board level committees, and in line with the relevant committee Terms of Reference, should provide assurance to the Board that risks within its remit (determined by the CRR and BAF), are being managed effectively by the risk owners, and report any areas of concern to the Board.

Clinical Directors, Assistant Directors and Heads of Service

Clinical Directors, Assistant Directors and Heads of Service are responsible for implementation of the Risk Management Framework and relevant policies and procedures, which support the health board's risk management approach.

As Senior Managers of the organisation, Clinical Directors, Assistant Directors and Heads of Service take the lead on risk management, and set an example through visible leadership of their staff. These responsibilities include:
- Taking responsibility for managing risk;
- Ensuring that risks are assessed where they are:
  o Identified within the working activities carried out within their management control;

- o Identified within the environment within their control;
- o Reported from the staff within their management control.
- Identifying and managing risks that cut across delivery areas;
- Ensuring all incidents/accidents and near misses are reported;
- Monitoring mitigating actions and ensuring action owners are clear about their roles, and what they need to achieve;
- Discussing risks on a regular basis with staff, and through discussions at meetings to help improve knowledge about the risks faced; increasing the visibility of risk management and moving towards an action focussed approach;
- Ensuring risks are updated regularly and acted upon;
- Communicating downwards what the health board's strategic risks are;
- Using the risk management process to support prioritisation and decision making;
- Ensuring staff are suitably trained in risk management;
- Promoting a risk aware culture in which staff are encouraged to identify and escalate risk;
- Ensuring that risk management is included in appraisals and development plans where appropriate;
- Ensuring the adoption and operation of the risk management framework across their work area.

Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility, and must be supported and enabled to manage these risks within a structured risk management framework. Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this Framework and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the health board's approach to risk management and governance. They will support the application of this Framework and its related processes, and participate in the monitoring and auditing process.

All Staff

All staff will:
- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety, and all others that may be affected by the health board's business;
- report all incidents/accidents and near misses;
- comply with the health board's incident and near miss reporting procedures;
- be responsible for attending mandatory and relevant education and training events;

- participate in the risk management system, including the risk assessments within their area of work, and the notification to their line manager of any perceived risk that may not have been assessed; and
- be aware of the health board's Risk Management Framework and processes, and the local strategy and procedures, and comply with them.

Contractors employed by the health board e.g. capital and estates specialists

It is the responsibility of each contractor employed by the health board to ensure that any staff working on their behalf is fully conversant with the risk management requirements for the activity for which they are engaged.

8.3 Internal Audit

The relationship between risk management and Internal Audit is critically important. Risk management is concerned with the assessment of risk and the identification of existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;

b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;

c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;

d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

8.4 Local Counter Fraud Services

The health board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The health board's Annual Counter Fraud Work Plan, as agreed by the Audit, Risk and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit, Risk and Assurance Committee as appropriate.

The LCFS works with the Chief Executive, Executive Directors and Board Secretary to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the health board's escalation process.

8.5 Committee Duties & Responsibilities

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee is responsible for overseeing risk management processes across the organisation, and will have a particular focus on seeking assurance that effective systems are in place to manage risk; that the organisation has an effective framework of internal controls to address strategic (principal) risks (those likely to directly impact on achieving strategic objectives); and, that the effectiveness of that framework is regularly reviewed.

The Committee is responsible for monitoring the assurance environment and challenging the levels of assurance in respect of key risks across the year, ensuring that the Internal Audit Plan is based on providing assurance that controls are in place and can be relied upon, and reviewing the internal audit plan in-year as the risk profiles change.

The Executive Committee

The Executive Committee has responsibility for ensuring implementation of the risk management process, and has responsibility for agreeing the risks on the CRR and the BAF, prior to consideration and approval by the Board.

The Executive Committee has the responsibility to discuss the BAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks, the current controls and assurances in place and the actions to address any gaps in these, prior to the BAF being submitted to the Board for consideration and approval.

It is also the role of the Executive Committee to agree that risks are being managed to an acceptable level, balancing priorities, resources and the risk to the health board, and recommending the best course of action to manage the risks, to the Board. The Board must be provided with assurance that everything that can be done is being done to reduce the risk, and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the health board. Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures will be regularly reviewed to ensure that they remain effective.

The Risk and Assurance Group

The Risk and Assurance Group is a management group of the Executive Committee. The Group reports to the Executive Committee and advises on any risk management issues, including all significant risks arising from activities within the organisation.

The Group is responsible for leading the implementation of the risk, control and assurance processes established within the organisation. The Group will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

- Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;
- Coordinating all clinical and non-clinical risk management issues affecting the health board (scored 12 and above), making recommendations to, and advising the Executive Committee and Board accordingly;
- Reviewing, updating and monitoring the Corporate Risk Register (CRR), and maintaining clear links with the Assurance Framework;
- Recommending the escalation and de-escalation of risks from/to the CRR for Executive Committee approval, ensuring significant risks are appropriately prioritised;
- Reviewing proposed significant risks from risk leads, escalating to the Executive Committee for inclusion in the CRR where appropriate;
- Reviewing risks arising from the results of investigations into losses, untoward incidents, near misses and accidents;
- Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the assurance framework appropriately.

Directorate Risk Management Arrangements
All directorates must have the necessary arrangements in place for good governance, quality, safety and risk management.

Directorates, through management, have responsibility for risks to their services and for putting in place appropriate arrangements for the identification, assessment and management of risks. Directorates are also responsible for developing local arrangements for monitoring risk registers and communicating risk information.

9. Risk Management Toolkit

To support delivery of the Risk Management Framework, a toolkit is available for staff on the intranet. The toolkit is a means by which the Risk Management Framework is operationalised to put into effect the full range of activities outlined. The toolkit includes:
- Risk Management Process
- Risk Assessment Procedure

- Risk Scoring Matrix
- Risk Register Procedure
- Risk Register Template & Guidance

10. Risk Management Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members	Risk Awareness Training & Review of Risk Appetite	Annual
Risk & Assurance Group / Senior Managers	Risk Awareness Training, including Risk Assessment and Risk Register Training	Every 3 Years
All Staff	Risk awareness training and an understanding of the role of risk management in the organisation	Every 2 Years
Service Managers / Risk Owners	Bespoke training delivered on a needs-based approach	Ad hoc / as required

11. Monitoring the Effectiveness of the Risk Management Framework

Compliance with this Framework is monitored by the Executive Committee and the Audit, Risk & Assurance Committee.

The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report.

The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year. The health board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process.

12. References

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Audit, Risk and Assurance Committee	Date of Meeting: 15th November 2022
Subject :	Transfer of the Community Health Councils Wales to the Citizen's Voice Body for Health and Social Care
Approved and Presented by:	Debra Wood-Lawson, Interim Director of Workforce and Organisation Development
Prepared by:	Chris Davies Senior W&OD Business Partner
Other Committees and meetings considered at:	Executive Committee, 19th October 2022

PURPOSE:
This paper provides an update on the arrangements and progress on the transfer of the Community Health Councils Wales (CHC) function, staff and resources from Powys Teaching Health Board to a newly created Welsh Government Sponsored Body on 1st April 2023. The report provides assurance on the planning and implementation of the transfer.
RECOMMENDATION(S):
The Audit, Risk and Assurance Committee is asked to **DISCUSS** the content of this paper, and identify any further assurance required on the progress being made to facilitate the transfer of the CHC staff and assets from PTHB to the newly created Citizens Voice Body (CVB) with effect from 1st April 2023.

Approval/Ratification/Decision[1]	Discussion	Information
✘	✔	✘

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

EXECUTIVE SUMMARY:

The 2018 review into Health and Social Care in Wales, set out several recommendations which included improvements to services and a closer integration of health and social care across Wales. As a result, an independent national body, the Citizen Voice Body for Health and Social Care (Wales) (CVB) was established and will be fully functional from 1st April 2023. Current services undertaken by Community Health Councils across Wales will be abolished and transferred to the new CVB.

The legislation governing the CVB is outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020; supported by the Explanatory Memorandum to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 dated June 2020.

The process will be undertaken via a "TUPE style exercise," following the principals of the Transfer of Undertaking (Protection of Employment)

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

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Regulation 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 This is explicitly cited within Section 401 of the Health and Social Care (Quality and Engagement) (Wales) Act Explanatory Memorandum, June 2020.

It is proposed that circa 90 staff employed in the CHCs (Community Health Councils) will transfer to the CVB on April 1st 2023.

Currently the CHC staff are employed by PTHB and work under the direction of the CHC Chief Officers, CHC Chief Executive and CHC Boards. The proposed change will transfer the employment of staff and resources to the CVB.

DETAILED BACKGROUND AND ASSESSMENT:

Background

A 2018 Parliamentary review into Health and Social Care across Wales outlined several recommendations for improvements to services across Wales. The review identified that the current systems were not fit for future and the focus was on developing 'a system of seamless health and care for Wales'. On 1st June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ('the Act') became law.

The introduction of the Act established a new organisation; the Citizen Voice Body for Health and Social Care in Wales (CVB) and will drive closer integration of both Health and Social Care across Wales. The aim of the CVB will be to:

- strengthen the citizen voice in Wales in matters related to both health and social services, ensuring that citizens have an effective mechanism for ensuring that their views are heard
- ensure that individuals are supported with advice and assistance when making a complaint in relation to their care
- use the service user experience to drive forward improvement.

The CVB was established as a body corporate in April 2022. The CVB is a Welsh Government Sponsored Body and 'the Act' requires that the CVB operates independently of Welsh Government, NHS Organisations, and care providers. The CVB will be structured so that it can perform at national, regional, and local levels, working closely with NHS bodies, local authorities, and other relevant persons/organisations. The CVB will provide an additional avenue to strengthen the public voice regarding health and social services across Wales to support continuous improvement of person-centred services.

There are currently 7 CHCs who represent the patient and public voice for health across Wales along with an Administrative Board Office Although

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operating independently, the 7 CHCs and Board are hosted by Powys Teaching Health Board (PTHB. With the introduction of the CVB, the current 7 CHC's and Administrative Board will be abolished from their current set up and the CVB will be formally constituted, effective from 1st April 2023.

Shortly before the Act became law, a Welsh Government Programme Board was created to support the establishment of the CVB. The Programmes Senior Responsible Officer (SRO) is Dr Chris Jones, Deputy Chief Medical Officer for Wales.

Planning and Implementation of the Transfer

To support and progress the establishment of the CVB, the CVB Implementation Board was created and is led by Hazel Robinson, the Implementation Director. The CVB Implementation Board includes representatives of the CHC's, Workstream Chairs, WG Programme members, PTHB, NWSSP and CVB Board members.

The CVB Implementation Board meets monthly and is supported by 7 interdependent workstreams, each responsible for core areas of activity to support the progression of the Programme. Chairs of each workstream meet monthly to discuss issues and cross-cutting themes. The supporting workstreams and Chairs are:

Workstream	Chair/Lead
Governance	Sioned Rees/Steve Elliot
Finance	Sioned Rees/Steve Elliot
People and HR	Helen Arthur/Rebecca Gorman
Locations	Richard Baker
Legislation	Anthony Jordan
Communications	Ben Eaton
Digital, Data and IT	Glyn Jones

CVB Board members were appointed between 1st April 2022 and 1st July 2022 and include:

- **Chair** – Professor Medwin Hughes
- **Deputy Chair** – Grace Quantock
- **6 non-executive members**- Bamidele Adenipekun, Jason Smith, Barbara Harrington, Karen Lewis, Rajan Madhok, Jack Evershed
- **Chief Executive** - Alyson Thomas (see below)

Chief Executive

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An internal selection process commenced on August 16th 2022 restricted to current CHC Chief Officers and the Acting CHC Chief Executive, to appoint an interim CVB Chief Executive for a period of up to 12 months.

Transfer of the CHCs to the CVB

The People and HR Workstream is responsible for managing and supporting the transfer of approximately 90 staff from the CHC's to the CVB. The group meet weekly, as does the subgroup.

Several meetings have been held within the CHC, so that staff are regularly updated with information relating to the establishment of the CVB. Additionally, staff sessions with the Welsh Government Programme Board SRO, Dr Chris Jones and the People and HR workstream Chair, Helen Arthur took place in August and September 2021 and in March and June 2022. A frequently asked questions document was developed following the 2021 and March 22 sessions to respond to initial queries and concerns raised. Further sessions are now planned over the coming weeks and months.

A joint consultation document has been drafted with a planned launch expected in November. Virtual consultation meeting dates are planned to run concurrently during the consultation period.

An initial collective meeting with the joint HR Leads and the recognised Trade Unions took place on September 22nd to inform the group of current progress and to forward plan future meetings to ensure communication and consultation remains open and regular.

TUPE 'style' transfer

As the transfer from the CHC's to the CVB involves staff moving from the CHC's to the CVB., the Welsh Ministers have committed to following a "TUPE style exercise". This is the same as would happen if organisations moved within the NHS in Wales, including the recent transfer in to PTHB of the local PH teams from Public Health Wales.

Welsh Government has issued guidance in the "Code of Practice on Workforce Matters," June 2014, and states the following:

Section 23 outlines: *"The Cabinet Office Statement6 (incorporated in the Code of Practice) provides that contracting exercises (including retendering) should be conducted on the basis that the Transfer of Undertakings (Protection of Employment) Regulations 20068 (TUPE) should apply unless there are genuinely exceptional reasons for it not to do so. The Statement recommends that at the earliest appropriate stage in the contracting exercise, the contracting authority should state that staff should transfer, and this should*

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normally have the effect of causing TUPE to apply. The Statement says that the UK Government expects all contracting authorities to follow this policy, which also provides that in circumstances where TUPE may not strictly apply in legal terms, the principles of TUPE should be followed, and the staff should be treated no less favourably than they would have been had the regulations applied".

When transferring from one employer to another, the transferor (PTHB) will need to provide specific information to the transferee (CVB) so that due diligence can be undertaken and so that employment records can be transferred. This is called employee liability information. Initial higher-level data has been shared and this will continue to be reviewed and updated up and until transfer.

Under TUPE regulation, workplace pension schemes are exempt from protection so do not automatically transfer. Any pension contributions paid into NHS Pension schemes up to the date of transfer are protected. TUPE regulations require that a reasonable alternative scheme be offered as part of the transfer.

The NHS Wales Shared Services Partnership has written to the NHS Pensions Agency on behalf of the CVB to seek Admitted Body Status so that staff may remain in the NHS Pension Scheme when they transfer to the CVB. The NHS Pensions Agency has confirmed that existing staff will be able to remain in the NHS pension scheme, and it is anticipated that 'Open' status will be approved shortly allowing newly recruited staff to also be admitted into the NHS pension scheme.

Those affected by the transfer

All current CHC employees with a contract of employment with PTHB, which extends beyond 31st March 2023, will be subject to the transfer. This includes employees who are on sick leave, maternity, paternity, or adoption leave.

Any employees with a fixed term contract that expires before 1st April 2023, for a reason not connected to the transfer to the new CVB will not transfer (there are currently 2 members of staff who fall into this category).

The consultation process

In line with TUPE Regulations, the transferor (PTHB) and the transferee (CVB) have obligations to inform and consult with 'appropriate representatives' of affected staff and this document should be treated as forming part of this process.

Consultation involves a genuine sharing of views and information on the proposed measures and provides an opportunity for staff and their representatives to influence decisions. However, the employer proposing the Measure has the legal right to make any final decisions. The purpose of consultation does not extend to the establishment of the CVB or its agreed functions.

Whilst several staff information sessions have been held, a formal consultation for the transfer will need to take place. There is no prescribed time limit for consultation as part of TUPE, however it is proposed that a formal consultation period will start on 1st November 2022 and end on 31st December 2022, so that the transfer can successfully take place on 1st April 2023.

Trade Union, staff representatives and affected staff will be consulted with directly and will be kept informed of developments throughout this period. PTHB and the People and HR Workstream leads will undertake any communications and meetings jointly, as far as is practically possible. As the transferor and as the employer PTHB will also ensure effective communication directly with staff who are affected by the transfer takes place.

Staff will have the opportunity to be involved, express their views as far as they relate to the areas covered by the Measures, and participate in the process either directly, or through appointed representatives. There will be a variety of mechanisms available to facilitate this:

- Joint meetings will be held with trades union representatives of affected staff to discuss the paper and consult on the Measures. This will also be an opportunity for trades union representatives to ask any questions, discuss any concerns and/or present views for consideration under consultation.
- Completion of the feedback form
- Email queries/issues to their People/HR representatives
- Group or individual meetings available on request, to discuss and address any concerns that staff may have, which are not limited to, the implications of the transfer, any concerns, individual needs, or personal information

Staff are entitled and encouraged, to be accompanied by a trade union or staff representative at any meeting, who can support them throughout the consultation process.

The draft consultation paper is attached at Appendix 1 for information.

After the consultation period

Once the formal consultation period has ended, all comments, feedback, questions, and discussions on the Measures will be fully considered and a formal response will follow.

Employee information will be passed from PTHB as the transferor to the CVB as the new employer. This exercise will be undertaken by the supporting HR/People teams and with the support of information governance teams to ensure that we meet our obligations under UK GDPR legislation.

Proposed Measures for transferring staff

As part of TUPE 'style' exercise process, 'Measures' are any changes to working practices that are proposed as part of the transfer. Under TUPE Regulations, PTHB and CVB has a duty to inform and consult on any Measures they intend taking prior and post transfer.

'Measures' may include any proposed restructure, amendments to terms and conditions and/or working practices.

The consideration of proposed Measures is an iterative process, and PTHB and the Welsh Government, on behalf of the CVB, are committed to ensuring that the transfer of staff goes as smoothly as possible. The organisations involved are committed to ensuring staff affected by the transfer have as much information as is reasonably practicable.

The TUPE 'style' consultation ends on the date of transfer, however the CVB will continue to consult on any changes that will not take effect immediately upon transfer (e.g. location if the change of location does not coincide with the TUPE 'style' transfer date). Staff will be supported as necessary by their trade union representatives and individual consultative meetings will also be offered. It will be the CVB's responsibility to continue to consult with staff on any changes that do not relate to the transfer, and which may take effect following the transfer to the CVB.

At this time the Measures to be included in the consultation document are as follows.

Monthly Pay Date: CHC staff are currently paid on 20th of the month. Once transferred to NWSSP Payroll, staff will be paid on the 21st of the month. This recommendation is made based on the existing NHS payroll system and processes and the inability to operate two payroll dates within the same organisation.

Pension: Under TUPE regulation, workplace pension schemes are exempt from protection so do not automatically transfer. Any Pensions paid into NHS Pension schemes up to the date of transfer is protected. TUPE regulations require that a reasonable alternative scheme be offered as part of the transfer.

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The NHS Wales Shared Services Partnership has written to the NHS Pensions Agency on our behalf to seek Admitted Body Status so that staff may remain in the NHS Pension Scheme when they transfer to the CVB. The NHS Pensions Agency has confirmed that existing CHC staff will be able to remain in the NHS pension scheme. It is anticipated that the CVB will be granted 'open' status so new recruits may also join the scheme

Benefit Schemes: CHC (Powys THB) currently offer staff a variety of salary sacrifice schemes.

With the exception of the Car Lease Scheme, which is no longer available to new applicants; the CVB will endeavour to support staff to continue their participation in such schemes as far as is practically possible.

Site Location: At this present time, all current CHC sites will remain and be transferred over to the CVB on 1 April 2023. Operational locations may change in the future. The CVB will consult appropriately as and when more information becomes available.

Overall Structure, and reporting arrangements and job descriptions:

To a large extent, the CVB will do much of the same work as the CHC's have done but will extend across the health and social care sectors so there are likely to be many similarities. However, the CVB Board will be designing the new body so there maybe new ways of working and the current the 7 Board structure is replaced by 1 within the legislation.

It is anticipated that the majority of staff transferred will continue to work to their current line management arrangements. In a small number of cases, staff may be required to work to an alternative line manager/ manage different staff. The impact on such staff will be discussed as part of the transition process.

Any changes to structures and job descriptions, known prior to transfer, will be discussed directly with the individuals affected as part of the process. However, any proposed changes made after the CVB implementation date of 1st April 2023 will be undertaken via the All-Wales Organisational Change Policy. PTHB will no longer be the employer and therefore this will be undertaken by the CVB as the new employer.

Staff policies

Staff policies and procedures will roll forward to the CVB. As the CVB is a new independent body it is anticipated that as policies come up to their review date, or if they are identified as an operational priority, a full review will be taken to determine if they are fit for purpose for the new organisation. Staff representatives will be fully involved in these reviews. Where a Policy or

Procedure contains a benefit, it expected that TUPE 'style' will be honoured and there will be no detriment to staff who transfer.

NEXT STEPS:

- TUPE 'style' transfer letter sent to trade unions w/c 24th October 2022
- TUPE 'style' consultation letters issued to staff on 1st November 2022Consultation Launch on 1st November 2022
- Briefings and one-to-one meetings with affected staff between the 1st November 2022 – 31st December 2022
- TUPE 'style' transfer consultation closes 31st December 2022
- Consideration of feedback 1st – 31st January 2023
- Final consultation document issued - 1st February 2023
- Letters to staff from PTHB confirming the transfer and agreed Measures (as part of the transfer out) - 1st March 2023
- Transfer date and date on which the CVB will establish operating capability 1st April 2023

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	x				**Statement**
Disability	x				
Gender reassignment	x				*Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken*
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				

	Sexual Orientation	x				
	Marriage and civil partnership	x				
	Welsh Language	x				

Risk Assessment:					
	Level of risk identified				**Statement**
	None	**Low**	**Moderat**	**High**	The financial risks have been highlighted in the Finance section of this paper.
Clinical	x				
Financial			x		
Corporate		x			
Operational	x				
Reputational	x				

Appendix 1

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Joint Consultation Document: Community Health Council's (CHC) and CHC Board Office, hosted by Powys Teaching Health Board (PTHB) and Welsh Government on behalf of the Citizen Voice Body for Health and Social Care Wales (CVB).

Transfer of Community Health Council to Citizen Voice Body for Health and Social Care Wales

Recipients:
All affected CHC staff
Trade Union lead representatives

For Information:
Chair of the CHC
Chief Executive, PTHB
Board of the CVB
CVB Implementation Board
People and HR Workstream

Date of Issue: [1 November 2022] [Final document to be translated into Welsh]

31 October 2022

Dear Colleague,

Please find attached the consultation documentation and related appendices for the joint consultation of the 'TUPE style exercise' for the transfer of staff from the Community Health Council's (CHC) and the CHC Board Office, hosted by Powys Teaching Health Board (PTHB), to the Citizen Voice Body for Health and Social Care Wales (CVB) on 01st April 2023. The transfer is being undertaken in partnership with trade union colleagues.

The formal consultation period will commence on 01st November 2022 and will end on31st December 2022 so that the CVB can be operationally effective from 01st April 2023 in line with the legislative requirements. During this period, you have been asked to share your comments, feedback and responses either on an individual basis or through your representative in relation to the proposed 'measures' that are included in section 10 of the consultation document.

There are several ways in which you can do this, and these have been outlined in section 13 of the consultation document. Please contact Chris Davies or Emma Pascoe if you would like to arrange an individual one to one session. Should any staff require reasonable adjustment so that they are able to fully participate in the consultation, please contact Chris Davies. Contact information for Chris and Emma can be found in section 14 of the consultation document.

Please ensure that any comments, feedback or questions are submitted by no later than 31st December 2022, to ensure that they can be responded to fully. Once all comments, feedback and questions have been received a formal response will be provided.

Should you have any queries, please contact Chris Davies or Emma Pascoe in the first instance.

Yours sincerely

==Carol Shilabeer (PTHB CEO)==

==Medwin Hughes (Chair of CVB)==

==Alyson (Interim Chief Executive Officer of the CVB)==

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Appendices: **See attached documents**

DRAFT

1. INTRODUCTION

A 2018 review into Health and Social Care in Wales, set out several recommendations which included improvements to services and a closer integration of health and social care across Wales. As a result, an independent national body, the Citizen Voice Body for Health and Social Care (Wales) (CVB) was established and will be fully functional from 1st April 2023. Current services undertaken by Community Health Council's across Wales will be abolished and transferred to the CVB.

The legislation governing the CVB is outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020; supported by the Explanatory memorandum to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 dated June 2020.

This document has been prepared to facilitate formal consultation with staff and Trade Unions on the abolition of Community Health Council's (CHC's) and the CHC Board Office' and the transfer of these staff to a newly formed CVB.

The process will be undertaken via a "TUPE style exercise", following the principles of the Transfer of Undertaking (Protection of Employment) Regulation 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014. This is explicitly cited within Section 401 of the [Health and Social Care (Quality and Engagement) (Wales) Act Explanatory Memorandum,](#) June 2020.

2. BACKGROUND

A 2018 Parliamentary review into Health and Social Care across Wales outlined several recommendations for improvements to services across Wales. The review identified that the current systems were not fit for future and the focus was on developing 'a system of seamless health and care for Wales'. On 1st June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ('the Act') became law.

The introduction of the Act established a new organisation; the Citizen Voice Body for Health and Social Care in Wales (CVB) and will drive closer integration of both Health and Social Care across Wales. The aim of the CVB will be to:

- strengthen the citizen voice in Wales in matters related to both health and social services, ensuring that citizens have an effective mechanism for ensuring that their views are heard
- ensure that individuals are supported with advice and assistance when making a complaint in relation to their care
- use the service user experience to drive forward improvement.

The CVB was established as a body corporate in April 2022. The CVB is a Welsh Government Sponsored Body and 'the Act' requires that the CVB operates independently of Welsh Government, NHS Organisations, and care providers. The

CVB will be structured so that it can perform at national, regional, and local levels, working closely with NHS bodies, local authorities, and other relevant persons/organisations. The CVB will provide an additional avenue to strengthen the public voice regarding health and social services across Wales to support continuous improvement of person-centred services.

There are currently 7 CHC's who represent patient and public voice for health, across Wales along with an Administrative Board Office. Whilst the CHC's, operate geographically across each area of Wales, they are hosted by Powys Teaching Health Board (PTHB). With the introduction of the CVB, the current 7 CHC's and Administration Board will be abolished from their current set up and the CVB will be formally constituted, effective from 1st April 2023.

3. THE CITIZEN VOICE BODY (CVB)

Shortly before the Act became law, a Welsh Government Programme Board was created to support the establishment of the CVB. The Programmes Senior Responsible Officer (SRO) is Dr Chris Jones, Deputy Chief Medical Officer for Wales.

CVB Implementation Programme and Board was created and is led by Dr Chris Jones as Senior Responsible Office (SRO) for the programme. The CVB Implementation Board includes representatives of the CHC's, Work Stream Chairs, WG Programme members, PTHB, NWSSP and CVB Chair as well as other key stakeholders.

The CVB Implementation Board is supported by 7 interdependent workstreams, each responsible for core areas of activity to support the progression of the Programme. Chairs of each workstream meet monthly to discuss issues and cross-cutting themes. The supporting workstreams and Chairs are:

Workstream	Chair/Lead
• Governance	Sioned Rees/Steve Elliot
• Finance	Sioned Rees/Steve Elliot
• People and HR	Helen Arthur/Rebecca Gorman
• Locations	Richard Baker
• Legislation	Anthony Jordan
• Communications	Ben Eaton
• Digital, Data and IT	Glyn Jones

CVB Board members were appointed between 1st April 2022 and 1st July 2022 and include:
- Chair - Medwin Hughes
- Deputy Chair - Grace Quantock
- 6 non-executive board members - Bamidele Adenipekun, Karen Lewis, Barbara Harrington, Jack Evershed, Rajan Madhok, Jason Smith
- Chief Executive (interim appointment) – Alyson Thomas

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From April 2023 when the CVB is fully operational the CVB Board will also include a Trade Union Independent member.

Section 12 and Schedule 1 (9) (1) of the Health and Social Care (Quality and Engagement) (Wales) Act 2022 makes provision about the Bodies constitution and enables the non-executive members to appoint a chief executive. Once the chief executive is in post the board is fully constituted, therefore the CVB will be able to undertake preparatory work towards establishing and operationalising the Body by 1 April 2023 (when substantive provisions in Part 4 of the Act are intended to be commenced).

4. TRANSFER OF THE CHC'S TO THE CVB

The People and HR Workstream is responsible for managing and supporting the transfer of approximately 90 staff from the CHC's [and the CHC Board Office] to the CVB.

A task and finish group has also been established to support the People and HR Workstream to ensure the people related systems and processes are in place to support the transfer.

The transfer of the CHC's to the CVB will be undertaken via a 'TUPE style exercise' referred to throughout this document as TUPE. See section 5 for further information on TUPE.

Several staff meetings have been held within the CHC [and the CHC Board Office], so that staff are regularly updated with information relating to the establishment of the CVB. Additionally, staff sessions with the Welsh Government Programme Board SRO Dr Chris Jones and the People and HR workstream Chair, Helen Arthur took place in August/September 2021 and in March and June 2022. Frequently asked questions documents were developed following staff sessions to respond to initial queries and concerns raised, the most recent copy can be found in Appendix 1.

In addition to the staff members, the CHC's are supported by approximately 280 volunteers. Whilst the volunteers will not form part of the TUPE transfer, as a key stakeholder, all volunteers will be kept informed of transfer plans. Current volunteers will be offered the opportunity to enter a new volunteer engagement with the CVB. This process will be facilitated by the HR and People Workstream.

5. TUPE 'STYLE' TRANSFER

'TUPE' stands for Transfer of Undertaking (Protection of Employment) and is regulated by the Transfer of Undertakings (Protection of Employment) Regulation 2006, amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) Amendment) Regulation 2014.

TUPE is a regulation that protect staff rights when they are involved in a transfer from one organisation to another by preserving continuity of employment and terms and

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conditions.   Under the TUPE Regulations, we have a duty to inform and consult with 'appropriate representatives' on any 'measures' (changes in work practices) that the transfer will bring.

The transfer from the CHC's and the CHC Board Office to the CVB involves staff moving from the CHC's and the CHC Board Office to the CVB, the Welsh Ministers have committed to following a "TUPE style exercise". **For the avoidance of doubt, this means that staff will have their continuity of service and terms and conditions protected.**

Welsh Government has issued guidance in the "Code of Practice on Workforce Matters", June 2014, and states the following:

Section 23 outlines: *"The Cabinet Office Statement[6] (incorporated in the Code of Practice) provides that contracting exercises (including retendering[7]) should be conducted on the basis that the Transfer of Undertakings (Protection of Employment) Regulations 2006[8] (TUPE) should apply unless there are genuinely exceptional reasons for it not to do so. The Statement recommends that at the earliest appropriate stage in the contracting exercise, the contracting authority should state that staff should transfer and this should normally have the effect of causing TUPE to apply. The Statement says that the UK Government expects all contracting authorities to follow this policy, which also provides that in circumstances where TUPE may not strictly apply in legal terms, the principles of TUPE should be followed and the staff should be treated no less favourably than they would have been had the regulations applied".*
https://gov.wales/sites/default/files/publications/2019-02/circular-code-of-practice-on-workforce-matters.pdf

When transferring from one employer to another, the transferor (PTHB) will need to provide specific information to the transferee (CVB) so that due diligence can be undertaken and so that employment records can be transferred. This is called employee liability information.

When the CHC and the CHC Board Office is abolished, staff will be transferred to become employees of the CVB along with their protected contractual terms and conditions of employment subject to the proposed measures outlined in Section 10.

Under TUPE regulation, workplace pension schemes are exempt from protection so do not automatically transfer.   Any Pensions paid into NHS Pension schemes up to the date of transfer is protected.   TUPE regulations require that a reasonable alternative scheme be offered as part of the transfer.

The NHS Wales Shared Services Partnership has written to the NHS Pensions Agency on our behalf to seek Admitted Body Status so that staff may remain in the NHS Pension Scheme when they transfer to the CVB. **The NHS Pensions Agency has confirmed that existing staff will be able to remain in the NHS pension scheme.** We are now seeking approval for any new CVB staff to also be admitted into the scheme, but this hasn't been confirmed as yet.

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6. WHO IS AFFECTED BY THE TUPE TRANSFER?

All CHC and CHC Board Office employees with a contract of employment with PTHB which extends beyond 31st March 2023 will be subject to the transfer. This includes employees who absent due to sickness, maternity, paternity, or adoption leave.

Any employees with a fixed term contract that expires before 1st April 2023, for a reason not connected to the new CVB will not transfer.

Volunteers of the CHC, as outlined above, have been included in discussions as a key stakeholder. They are not employees so will not transfer under TUPE. However, volunteers will be offered the opportunity to enter a new voluntary agreement with the CVB.

7. CONSULTATION: THE PROCESS

In line with TUPE, the transferor (PTHB) and the transferee (CVB) have obligations to inform and consult with 'appropriate representatives' of affected staff and this document should be treated as forming part of this process.

Consultation involves a genuine sharing of views and information on the proposed measures (please see section 9 for further information on measures) and provides an opportunity for staff and their representatives to influence decisions. However, the employer proposing the measure has the legal right to make any final decisions. The purpose of consultation does not extend to the establishment of the CVB or its agreed functions. The consultation will be full, fair, and meaningful.

Whilst several staff information sessions have been held, a formal consultation for the transfer will take place. There is no prescribed time limit for consultation as part of TUPE, however it is proposed that a formal consultation period will start on 1st November 2022 and end on 31st December 2022, so that the transfer can take place on 1st April 2023.

A detailed timeline of what will be included during and following the formal consultation period has been included under section 12.

Trade Union, staff representatives and affected staff will be consulted directly and will be kept informed of developments throughout this period. PTHB and the People and HR Workstream leads will undertake any communications and meetings jointly as far as is practically possible. As the transferor, PTHB may also communicate directly with staff who are affected by the transfer.

Staff will have the opportunity to be involved, express their views in so far as they relate to the areas covered by the measures, and participate in the process either directly or through appointed representatives. There will be a variety of mechanisms available to facilitate this.
- Joint meeting/s will be held with trades union representatives of affected staff to discuss the paper and consult on the measures outlined in section 10. This

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will also be an opportunity for trades union representatives to ask any questions, discuss any concerns and/or present views for consideration under consultation.

- Completion of the feedback form which is included in Appendix 2.
- Email queries/issues to their People/HR representatives, please see section 14, for contact information.
- Group or individual meetings available on request, - to discuss and address any concerns staff may have, which are not limited to, the implications of the transfer, individual needs or personal information.

Should any staff require reasonable adjustment so that they are able to fully participate in the consultation, please contact Chris Davies. Please refer to section 14 for contact information.

Staff are entitled and encouraged, to be accompanied by a trade union or staff representative at any meeting, to support them throughout the consultation process. Contact details for trade unions and staff side representatives can be found in section 14.

8. CONSULTATION: WHAT HAPPENS AFTER?

Once the formal consultation period has ended, all comments, feedback, questions, and discussions on measures will be fully considered and a formal response will follow.

Employee information will be passed from PTHB as the transferor to the CVB as the new employer. This exercise will be undertaken by the supporting HR/People teams and with the support of information governance teams to ensure that UK GDPR law is followed.

Should staff have any queries at any stage, they should contact the relevant person outlined in section 14.

9. 1ST APRIL 2023: WHAT HAPPENS ON AND AFTER?

1st April 2023 is the date in which the CVB becomes fully operational. All transferred staff will be employed by the CVB from this date. Staff will not receive a new contract of employment as continuity of service and contractual terms and conditions of employment will automatically transfer. They will however receive a letter confirming details of the transfer.

To welcome and support the transition into the CVB, an induction and training programme will be created. Further details regarding these programmes will be provided closer to transfer date.

After transfer, the CVB Board will continue to consult with staff and appropriate representatives regarding any outstanding measures.

The CVB as a new employer has a duty to ensure that all employees have the necessary employment checks. Following transfer, the CVB will need to ensure that as a minimum all staff have the right to work in the UK.

Should staff have any queries relating to the TUPE transfer or terms and conditions following transfer they should contact Chris Davies or Emma Pascoe. Please refer to section 14 for contact information.

10. PROPOSED MEASURES FOR TRANSFERRING STAFF

As part of TUPE style exercise, 'measures' are any changes to working practices that are proposed as part of the transfer. Under TUPE, PTHB and CVB has a duty to inform and consult on any 'measures' they intend taking prior and post transfer.

'Measures' includes anything other than the fact of the transfer and may include restructures, terms and conditions or working practices.

The consideration of proposed measures is an iterative process, and PTHB and the Welsh Government on behalf of the CVB are committed to ensuring that the transfer of staff goes as smoothly as possible. The organisations involved are committed to ensuring staff affected by the transfer have as much information as is reasonably practicable.

The consultation is an on-going and iterative process. Whilst all of the information may not be available at the start of the formal consultation, the organisations involved are keen to begin the process to allow staff to discuss any issues with their representatives. PTHB and CVB are seeking feedback and a response to the measures proposed with a view to reaching an agreement on the issues identified. The TUPE consultation ends on the date of transfer, however CVB will continue to consult on any changes that will not take effect immediately upon transfer (e.g. location if the change of location does not coincide with the TUPE transfer date). It is recognised that staff may have questions and may wish to seek further clarification in respect of the proposals. Trade union representatives will be able to support staff through this process and will feedback comments throughout the consultation process. Individual consultative meetings will also be offered to any staff who wish to discuss particularly personal issues relating to the transfer.

The CVB will continue to consult with staff on any changes that do not relate to the transfer, and which may take effect following the transfer to CVB.

Throughout the consultation process, the proposed measures may be amended, added to, or withdrawn.

Monthly Pay Date	CHC staff are currently paid on 20th of the month. Once transferred to NWSSP Payroll, staff will be paid on the 21st of the month. This recommendation is made based on the existing NHS payroll system and processes and the inability to operate two payroll dates within the same organisation.

Pension	Under TUPE regulation, workplace pension schemes are exempt from protection so do not automatically transfer. Any Pensions paid into NHS Pension schemes up to the date of transfer is protected. TUPE regulations require that a reasonable alternative scheme be offered as part of the transfer. The NHS Wales Shared Services Partnership has written to the NHS Pensions Agency on our behalf to seek Admitted Body Status so that staff may remain in the NHS Pension Scheme when they transfer to the CVB. The NHS Pensions Agency has confirmed that existing CHC staff will be able to remain in the NHS pension scheme. They are now seeking approval for new CVB staff to also be admitted into the scheme, but this hasn't been confirmed as yet.
Benefit Schemes	CHC (Powys THB) currently offer staff a variety of salary sacrifice schemes, which include: • Childcare Voucher Scheme (only open to current members) • Cycle to work Scheme • Car Lease Scheme • Leisure discount scheme • Free eye test • Well-being at work break With the except of the Car Lease Scheme which is no longer available to new applicants; the CVB will endeavour to support staff to continue their participation in such schemes as far as practically possible.
Site Location	At this present time, all current CHC sites will remain and be transferred over to the CVB on 1 April 2023. Operational locations may change in the future but this is unknown at present. We will consult appropriately as and when more information becomes available.
	As outlined above, the CVB will drive closer alignment of both Health and Social Care across Wales. As a new single, standalone organisation our response to this will naturally require a different governance arrangement and expanded remit. Our need to operate as a corporate body, with the inclusion of social services across the nation will present an exciting new agenda for us all. In addition, a strong guiding principle of accessibility and inclusion has been identified, meaning that the CVB needs to consider the different methods, audiences and models of engagement and representation it will use. There is a keenness to reflect a culture of

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	meaningful engagement and strong partnership working with bodies operating in health and social care.
Overall Structure and reporting arrangements	There are a number of overarching themes that have received common agreement between CVB Board members: • Complaints Advocacy • Health and Social Services Alignment • Patient and Service User Safety • Public Communication & Engagement • Professional Partnerships & Representation • Volunteers • Equality, Diversity, Inclusion and Welsh Language. We will work to a number of operating principles: • As a single organisation, we will be structured so we can perform at local, regional and national levels • We will maintain a regional structure to best serve our local citizens • We will have a new senior structure between the Chief Executive Officer and regional roles • We will have a senior management team in order to share a collective responsibility to deliver the objectives of the corporate and regional agendas • We will all harness being part of a single, all Wales body to pool our ideas, strengths and expertise It is anticipated that the majority of staff transferred will continue to work to their current line management arrangements. In a small number of cases staff may be required to work to an alternative line manager / manage different staff. The impact on such staff will be discussed as part of the transition process. It is proposed that the Chief Officer roles will evolve and change to meet the new operating principles of the organisation. Individual discussions will take place so that we develop these roles with the staff involved. To reduce uncertainty, it should be noted these jobs will exist at the same level as they are now but will be reframed in response to the different governance arrangements and requirement to develop strong partnerships with local authority colleagues. Similarly, the Business Manager role descriptions will change to reflect the move to a single, standalone organisation. These roles will still exist.

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| | There will also be a number of new posts, including those dedicated to complaints advocacy. Further information will be provided over the next few months as these roles are developed and confirmed. |
| | Any changes to structures and job descriptions known prior to transfer will be discussed directly with the individuals affected as part of the process. However, any proposed changes made after the CVB implementation date of 01st April 2023 will be undertaken via a job description review process as necessary. |

11.   STAFF POLICIES

Staff policies and procedures will roll forward to the CVB. As the CVB is a new independent body it is anticipated that as policies come up to their review date or if they are identified as an operational priority, a full review will be taken to determine if they are fit for purpose for the new organisation. Staff representatives will be fully involved in these reviews. Where a Policy or Procedure contains a benefit, it expected that TUPE (style) will be honoured and there will be no detriment to staff who transfer.

A full listing is outlined in Appendix 3.

12.   TIMELINE OF EVENTS

The project aims to follow the timetable outlined below and will have a transfer date of **1st April 2023**. All steps outlined in the timetable will be undertaken jointly between PTHB and CVB.

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Activity	Date
TUPE letter sent to trade unions	w/c 24 October 2022
TUPE consultation letters issued to staff	1 November 2022
Consultation Launch	1 November 2022
Trade Union Representative meetings and any one-to-one meetings with affected staff	1 November 2022 – 31 December 2022
TUPE consultation closes	31 December 2022
Consideration of Feedback *(feedback form included at Appendix2)*	1 – 31 January 2023
Final Consultation Document Issued	1 February 2023
Letters to staff from PTHB confirming the transfer and agreed measures (transfer out).	1 March 2023
Welcome letter to CVB staff (transfer in).	1 March 2023
Transfer date and date on which the CVB will establish operating capability	1 April 2023

13. CONSULTATION: RESPONSE OPTIONS

Staff views and feedback on the proposals outlined within this document are welcomed and requested. There are a variety of ways in which this can be undertaken.

Responses can be emailed directly to either Chris Davies or Emma Pascoe using the feedback form which is included in Appendix 2. Please ensure that any comments, feedback or responses are sent and received no later than 31st December 2022 so that they can be fully considered.

Additionally, comments can be made via representatives, please see contact details for the trade union and staff representatives involved in the transfer:

Should you have any queries relating to the consultation, please see the contact information included in the section below.

14. CONTACT DETAILS

For further information or should you wish to make any comments on the content of this document, please contact the following:

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Name	Role	Contact Email
Emma Pascoe	*People Project Manager*	emma.pascoe@wales.nhs.uk
Christopher Davies	*Senior Workforce Business Partner, PTHB*	christopher.davies6@wales.nhs.uk

Name	Representing Unions	Contact Email
Paul Gage	GMB	Paul.Gage@gmb.org.uk
Cathie Poynton	Unison	Cathie.Poynton@wales.nhs.uk
Sam Crane	MIP	s.crane@miphealth.org.uk
Jono Davies	Unite	jono.davies@unitetheunion.org

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Frequently Asked Questions (FAQ) from TUPE staff sessions (Aug-Sept 2021)

Citizen Voice Body (CVB) Establishment- Decision Making (between now and 2023).

It is important the CVB is established in a way which enables independent decisions to be taken by its Board, as soon is practically possible, to inform how it will be structured and operate from 01 April 2023. Ahead of this date the CVB Implementation Board (previously the steering group), the supporting work streams and the Board of the Citizen Voice Body (when appointed) will work closely to appropriately support and progress establishment of the CVB by 01 April 2023.

Q1. Can we have something which explains who is responsible for making different decisions? It is complicated with WG, CVB programme board and shadow board all being mentioned. How can we as staff feed into these?

A. Yes. The Establishment Programme (which includes representatives of the CHC's) have developed a Decision Making Framework to make it clear who is responsible for what decision. This DMF is founded on 3 key principles;

1) The CHC's are able to continue to deliver services.
2) The Board of the Citizen Voice Body (once appointed) will be the principal driver for how the body should function and the chief decision maker.
3) Where decisions have to be made prior to the Board of the Citizen Voice Body being in place to ensure the body is able to 'go live' 01 April 2023, they will be made by the Implementation Board (that includes representatives of the CHC's), be as minimal impact as possible, and be as flexible as possible so the Board of the Citizen Voice Body is able to decide things for itself..

Q2. When will the CVB Chair be appointed? Who's responsible for this, is it Welsh Government?

A. The Minister for Health and Social Services is responsible for the appointment of the Chair of the Board of the Citizen Voice Body. This role is currently being recruited to via the Public Appointment process.

Q3. When will Shadow board be in place, and who will be on it?

A. There will not be a CVB shadow board as we had thought. This is because the legislation does not allow us to form one but instead it says the full board is needed to make decisions. Therefore, the recruitment process for the full CVB board has been brought forward so it is in place as soon as is possible and they can take on decision making.

In addition to the Chair, the Board will comprise of, a Deputy Chair and Six Non-Executive Members and the Chief Executive. All of these roles (except the Chief Executive) are currently being recruited to through the Public Appoints Process. The CVB board will be known as the Board of the Citizen Voice Body and will be established once the Chief Executive is appointed.

Q4. When will the CEO be appointed?

A. From May 2022 the Board of the Citizen Voice Body, will begin to be involved in decisions about how the CVB will be structured and operate from 01 April 2023. The board will progress appropriate recruitment into specific roles such as the Chief Executive Officer, which are critical to the successful establishment of an operational CVB by 01 April 2023.

Q5. Will the CVB board run alongside the CHC, so we can continue with day-to-day running until transfer?

A. Yes. The CHC Board and all 7 CHCs will continue to be responsible for carrying out our role and delivering our services on a day to day basis. The Board of the Citizen Voice Body will operate independently of our CHC movement. We will have the opportunity to inform and influence its thinking and decision making through the Welsh Government's CVB implementation board and the CVB Programme work streams.

Q6. Will capacity be increased in CVB – i.e. will there be increased budgets, more staff will be needed as the remit expands to encompass Social Care?

A. Yes. The Welsh Government has recognised a need to increase capacity in the CVB. It's original estimate of the resources needed in the new body was set out in a 'Regulatory Impact Assessment'. This was published with the Health and Social Care (Quality & Engagement)(Wales) Act 2020 in a document called an Explanatory Memorandum. You can see this here.

Our CHC movement made clear in its oral and written evidence to the Senedd's Health and Social Care Committee that the new CVB should be sufficiently resourced (including financial resources) to enable it to meet its responsibilities effectively.

The Welsh Government's CVB Implementation Board will be responsible for overseeing the identification of the resources required for the new CVB. Our CHC movement will have the opportunity to inform and influence this process.

Q7. I know we are employed by PTHB currently, but I always tell people I'm employed by the CHC, which is independent. This is important with the type of work that we do. Who will our new employer be post transfer?

A. Your new employer will be the Citizen Voice Body for Health and Social Care, Wales. The new body will be an independent body which stands alone as an organisation but is sponsored by Welsh Government.

The Transfer Process

As the transfer from the CHCs to the CVB involves staff moving from the CHC's to the CVB, the Welsh Ministers have committed to following a 'TUPE style process'. This is the same as would happen if organisations moved within the NHS.

Q8. What is TUPE?

A. TUPE is the "Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014". TUPE's purpose is to preserve employees' terms and conditions when a business or undertaking is transferred to a new employer.

Q9. What does the TUPE style process mean for me?

A. This means that terms and conditions such as hours, annual leave and pay remain unchanged. Additionally, your service with the previous organisation will be taken into account for statutory and contractual entitlements such as maternity, occupational sick pay, redundancy pay.

Q10. How will this process affect me?

A. The process will be as seamless as possible. You will have opportunity to give your thoughts and comments on the new body and the transfer process. Your terms and conditions will remain the same. The CVB will do much of the same work as the CHC's have done, extended across the health and social care sectors so there are likely to be many similarities in what your day to day looks like. However, the CVB board will be designing the new body so there will no doubt also be new ways of working. You will be fully supported and trained prior to moving into your new posts in the CVB.

Q11. What will happen to my continuity of service when I transfer?

A. Your continuous service will transfer with you.

Q12. If I don't want to transfer to the CVB, can I be redeployed to another role in the NHS?

A. No, your role will automatically transfer to the new body. You are therefore not at risk and not eligible for either redeployment to an alternate role or redundancy payment. If you choose not to transfer to the CVB, this would be treated as a resignation from your post.

Terms & Conditions

Q13. Is my pay and pension protected during the transfer?

A**.** All express terms, including pay, are explicitly agreed between you and your employer and therefore protected when you transfer to the CVB. Pensions are not directly transferable to the new employer. However the Transfer of Employment (Pension Protection) Regulations provide that, the new employer must provide you with a scheme that is broadly comparable. For further information, please see Questions 10 and 14. https://www.legislation.gov.uk/uksi/2005/649/note?view=plain

Q14. Will the CVB change my terms and conditions after one year?

A. The CVB would need to consult with you on any changes to your terms and conditions. Your terms and conditions cannot be changed to something worse than before the transfer, unless your new employer has a valid Economic, Technical or Organisational reason**.** The period of protection afforded on transfer is **indefinite**; if the change to a transferring employee's terms and conditions of employment is because of the transfer, it will be prohibited, even if it occurs some years after the transfer took place.

Q15. What happens to the balance of an employee's accrued annual leave when they transfer to the CVB?

A. The balance of a transferring employee's annual leave entitlement for the annual leave year transfers to the new employer. The transferor does not have to pay the employee for accrued but untaken holiday at the date of transfer. The transferee must allow the employee to take the balance of the leave entitlement before the end of the annual leave year.

Pensions

Q16. What happens to contributions we have already made to the NHS scheme?

A. All contributions made to NHS pensions are protected for you, and retained in the scheme regardless of who the new pension provider will be. CVB Board will ultimately determine which pension scheme you will be enrolled into upon transfer to the CVB.

Q17. Will the CVB give us pension advice if they choose a different pension provider post transfer?

A. No, your employer and/or pension scheme provider cannot offer financial advice; they cannot tell you what the best action is for you to take, and can only provide factual information about your pension entitlement and options. However, should the CVB decide not to continue with the NHS scheme, it will need to provide you with full details of the scheme and highlight any differences with the scheme they will provide.

Temporary contracts

Q18. There are a number of staff on temporary contracts across the CHCs, what will happen to these staff?

A. We are aware of this and are currently reviewing each contract as there are different types of temporary contracts in place for a variety of reasons. Therefore, there is no one size fits all solution. Each is being carefully considered individually and affected employees will be contacted directly, in due course in order to explain how it will affect them.

Continuity of service delivery

Q19. What happens to any vacancies that will occur in the period pre-transfer?

A. This is something that is being considered at present, in order that we can arrive at a solution that ensures the ability of the board and each CHC to continue to function fully during the transfer period and also ensures the organisation is in a good position at the point of transfer to carry out the CVB duties.

Q20. We understand that there will be no roles for certain staff?

A. Everyone that transfers to the CVB will have a role and have their terms and conditions of employment protected.

Existing Additional Benefits - outside of T&Cs

Q21. Is it legal that we are being disadvantaged on account of the transfer with the salary sacrifice car scheme?

A. This salary sacrifice car scheme is a voluntary scheme and not contractual, therefore it would not be covered by a TUPE style process. The terms and conditions of the salary sacrifice car scheme prevent a contract duration extending beyond the CHC's existence. Therefore **NEW** contracts cannot be agreed. The establishment of any new scheme would be a decision for the CVB Board.

Trade Union

Q22. Are the Trade Unions aware of what is happening?
A. Yes, the recognised Trade Unions are fully aware of what has happened so far and we will ensure they are kept up to speed with developments. Discussions will be more prevalent as we move into the formal stages of the transfer, but you can of course contact them or submit questions via your Trade Union representative if you prefer.

Q23. Will my Trade Union be recognised?
A. Any trade union recognition will transfer across to the new employer. The trade union will get agreement from the new employer that recognition will continue.

Q24. What happens to my trade union subscriptions?
A. If you currently pay your subscriptions through your payroll then the trade union will negotiate with the new organisation for this to continue during the consultation process.

Location

Q25. When will we know where our offices will be located?
A. The Location work stream within the CVB establishment programme is considering all options available. Where physical buildings are located, is of course dependent on how the CVB wants to operate, and where it is best placed to allow people to access the CVB services.

As much as possible, it will be for the CVB board to make these decisions so at present the establishment programme will continue to maintain the offices as they are.

To make sure the CVB board is able to decide on its locations, the Welsh Government programme team will be ensuring all related decisions allow for several location options. For example, they will make sure all digital options are cloud based by default.

Q26. We understand that all services will be re-located to Cardiff?
A. No consideration has been given either in the CHC movement, or in the Welsh Government to re-locating all services to Cardiff. In making its decisions about locations, the CVB will have a statutory responsibility to demonstrate how it will be accessible to people in all parts of Wales, using the latest technology, as well as face to face engagement within its ways of working.

Support

Q27. Can I contact people in other CHCs in the same role? I know some roles already have 'networks' established, but not all of us have this?

A. We have now established virtual peer networks for all roles to allow you to share experiences and ask questions or submit ideas collectively. You are also able to feedback via our online feedback form, through our CVB work streams, via your Chief Officers and Chairs, or directly to the Board's Chief Executive or H.R. Business Partner. We are happy to engage with you in the way you feel most comfortable.

Q28. What training will be provided and by who?

A. The Welsh Government previously approved a change management/development training programme for all current CHC staff, to help in developing you in your current roles and to prepare you for new roles or opportunities in the CVB. This programme is currently under way and is being delivered by Academi Wales.

More recently, through the Decision Making Framework, the CVB Implementation Board agreed additional funding to offer ILM management training to eligible staff. This programme is funded by Welsh Government and will run from February 2022 for 18-24 months.

Q29. Can we re-start the society of staff?

A. If there are any proposals staff wish to put forward which will help with the transfer, we will happily look at these and give due consideration to them.

Decisions to be made by the Board of the Citizen Voice Body

CVB Organisational Design

Q30. We are aware that not every CHC has the same staff structure. Will structures in each existing CHC be uniformed in the CVB?

A. This will be a decision that the Board of the Citizen Voice Body will need to make based on its operational requirements.

Q31. Will the CVB change my job role?

A. It will be for The Board of the Citizen Voice Body to determine if any changes are required to roles in the new organisation. The new body will have a wider range of responsibilities to meet, so change in roles may be likely. If required, any changes will be made in consultation with you and ensuring that any required training is provided.

Q32. Where we know additional staff will be required i.e. with advocacy support roles, will current staff be given first opportunity to apply for new roles in the CVB or will it be subject to wider competition?

A. This will be a decision for the Board of the Citizen Voice Body to make in relation to recruitment to any new vacancies.

Q33. When will we know the types of roles and the number of each that the CVB will require? What will happen to roles duplicated across the new organisation?

A. It will be for the Board of the Citizen Voice Body to decide what the capacities are required in each role type. Our CHC movement will have the opportunity to inform and influence this through our involvement in the Welsh Government's CVB Implementation Board and work streams.

Pay & Pensions

Q34. Who decides on what pension scheme the CVB will use and when will we know?

A. The Board of the Citizen Voice Body will ultimately determine which pension scheme you will be enrolled into upon transfer to the CVB. However, there will need to be a 'working decision' made before the CVB Board is in place to allow for the transfer process to begin. This decision will be made by the SRO with advice from the CVB Implementation board and Welsh Government workforce experts.

Q35. Will we still get annual increments in the CVB?

A. The Board of the Citizen Voice Body will review and decide on the future pay structures. As soon as any updated information is available, we will share this with you.

Training

Q36. As the CVB will incorporate Social Care in addition to what the CHC already covers, roles will inevitably have to grow and diversify to accommodate these new requirements. What training will be provided and by who?

A. Our CHC movement's learning and development plans and priorities are already focusing on supporting our transition to the CVB. The Welsh Government's original estimates of the resources needed to establish the CVB, include provision for the costs of training identified as being necessary for CVB staff and volunteer members. As we move closer to establishing the CVB, training has been incorporated into the People and HR work stream.

The People, HR and learning work stream will work with the Board of the Citizen Voice Body to develop more detailed training plans for the Board, and its staff and volunteers. We will have the opportunity to inform and influence the development of these plans.

Academi Wales is delivering a 'Managing Change Successfully' programme for all of us. You can find out more information from your Chief Officer or the CHC Board office.

Existing Additional Benefits - outside of T&Cs

Q37. What will happen to those of us who have existing car leases that extend beyond the transfer date?

A. The arrangement for any **existing** car leases which extend beyond the transfer date will be dependent on whether the Board of Citizen Voice Body intends, and is accepted into offering the same car lease scheme. If so, NHS Wales Shared Services Partnership can arrange for the contracts to be transferred to the CVB. If not, then contracts will need to be terminated and early term charges will be payable by the organisation.

Future Service Provision

Q38. When will CHC complainants be informed that any complaints currently being dealt with, will possibly still be running into the period when the new body becomes operational?

A. The plans for the introduction of the CVB, including its planned operational date of 01 April 2023 has been announced publicly, so CHCs are able to make people aware in general terms about the introduction of the new Citizen Voice Body. We expect to agree more specific communication for existing clients who may be directly impacted by the introduction of the CVB closer to the implementation date.

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Appendix 3: TUPE Consultation Feedback Form

This feedback form is to be completed in relation to the TUPE transfer of Community Health Councils to the Citizen Voice Body for Health and Social Care Wales.

Please send the completed form to Emma Pascoe or Chris Davies by no later than **31st December 2022**. (Emma.Pascoe@wales.nhs.uk or Christopher.davies6@wales.nhs.uk).

Name:	
Location:	
Role:	
Date:	

Proposed Measure:	**Please include your feedback, comments, questions or concerns here:**
Monthly Pay Date:	
Pension:	
Benefit Schemes:	
Site Locations:	
Overall structure and reporting arrangements:	

Please include any other feedback, comments, questions or concerns relating to the consultation that are not directly related to the proposed measures:	

TUPE Consultation_Feedback Form_Sep 22

Appendix 4: Staff Policies and Procedures

Policy	CHC Status	Benefit contained in policy?	Review date
All Wales Policies:			
All Wales Dignity at Work and The Grievance Policies which are now combined as new AW Respect and Resolution Policy (HR09)	Adopted in full HR 009 Respect and Resolution Policy.pdf		Reviews are undertaken on an All-Wales basis through the Wales Partnership Forum
All Wales Disciplinary Policy (HR010)	Adopted with Amendments HR 010 - All Wales Disciplinary Policy & Procedure.pdf		As above
Confidentiality (IGP 012 All Wales Information Governance Policy (2021))	Adopted in full IGP 012 NHS Wales Information Governance Policy V2 Review Date January 2023.pdf		As above
Sickness Absence (now HR027 All Wales Managing attendance at work)	Adopted in full HR 027 All Wales Managing Attendance at Work Policy .pdf	Sick pay entitlement set out in main terms and conditions of employment issued on employment	As Above
All Wales Pay progression (HR 013)	Adopted in full HR 013 - All Wales Pay Progression Policy.pdf	Policy states how pay progression linked to performance against agreed targets is advanced	As Above
All Wales Capability Policy (HR012)	Adopted in full HR 012 All Wales Capability Policy & Procedure.pdf		As Above
All Wales Travel and Subsistence Policy (HR 015)	Adopted in full HR 015 - NHS Wales Travel and Subsistence Policy.pdf	Contains details for the reimbursement of expenses that have been necessarily incurred in the performance of their duties	As Above
All Wales Organisational Change Policy (HR 023)	Adopted in full HR 023 All Wales Organisational Change Policy .pdf	Policy contains details of pay protection, redundancy	As Above
All Wales Secondment Policy (HR 047)	Adopted in full HR 047 - All Wales Secondment Policy (English).pdf		As Above
All Wales Special Leave Policy (HR048)	Adopted in full		As Above

	HR 048 - All Wales Special Leave Policy English Combined.pdf		
All Wales NHS dress code (HR 079)	Adopted in full HR 079 All Wales NHS Dress Code Policy.pdf		As Above
All Wales Reserve Forces training and mobilisation policy (HR 084)	Adopted in full HR 084 - All Wales Reserve Forces Training and Mobilisation Policy.pdf		As Above
All Wales Menopause (HR094)	Adopted in full HR 094 NHS Wales Menopause Policy and Tool Kit.pdf		As Above
All Wales Employment Break Policy (HR095)	Adopted in full HR 095 - All Wales Employment Break Policy.pdf		As Above
Powys Teaching Health Board Staff Policies adopted by the CHC:			
Health & Safety (HSP 001)	Adopted in full HSP 001 Corporate Health and Safety Policy 2022.pdf		March 2025
Smoke Free Policy (EWP 010)	Adopted in full EWP 010 - PTHB Smoke Free Policy V7 Review Date March 2024.pdf		March 2024
Alcohol, drug, and substance misuse (HR 017)	Adopted in full HR 017 - Staff Alcohol, Drugs and Substances Policy V5 Review Date March 2025.pdf		March 2025
Whistleblowing (PTHB Procedure for NHS Staff to Raise Concerns HR 006)	Adopted in full HR 006 - PTHB Procedure for NHS Staff to Raise Concerns.pdf		No review date stated
Equal Opportunity Policy (Equality and Diversity Policy HR 060)	Adopted in full HR060 Equality & Diversity Policy		October 2013
Trade Union recognition agreement (HR064)	Adopted in full HR 064 - Trade Union Recognition Agreement .pdf		Jan 2023
Annual Leave (HR081)	Adopted in full HR 081 – Annual Leave Policy.pdf	Annual leave entitlement set out in main terms and conditions of employment issued on employment	Sept 2020

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Maternity, Paternity, Adoption and Surrogacy Policy & Procedure) (HR 007)	Adopted in full HR 007 Maternity, Paternity, Adoption and Surrogacy Policy & Procedure.pdf	Policy contains specific entitlements to both paid and unpaid time off work	Oct 2020
Overpayment (HR 101 Procedure for the Recovery of Overpayments to Employees)	Adopted in full HR 101 Procedure for the Recovery of Overpayments to Employees.pdf		No review date stated
Disclosure and Barring Service (HR 019)	Adopted in full (CHC have different DBS provider to Powys) HR 019 Disclosure and Barring Service Policy and Procedure V5 Review Date June 2025.pdf		June 2025
Mediation (HR002)	Adopted in full HR 002 Restoring Relationships (Mediation) A Simple Process.pdf		December 2022
Policy and procedure to determine starting salary (HR 004)	Adopted in full HR 004 Policy & Procedure for Determining Starting Salaries & Annual Leave V5 Review date July 2023.pdf	Policy confirms how a starting salary above bottom point can be applied for and what evidence is required for approval	July 2023
Recruitment Policy and Procedure (HR 011)	Adopted in full HR 011 – Recruitment and Selection Policy and Procedure.pdf		July 2023
Car lease policy (HR 003)	Adopted in full HR 003 - Lease Car Policy and Procedure.pdf	This policy sets out the terms and conditions of the All Wales Lease Car scheme in line with Annex M of the A4C handbook.	December 2024
Employee long service recognition and excellence awards (HR 005)	Adopted in full HR 005 - Employee Long Service Recognition & Excellence Awards Policy1.pdf	Policy contains details of financial award in recognition of service with PTHB	Aug 2023
Work Experience and Placement Policy (HR 008)	Adopted in full HR 008 - Work Placement and Work Experience Policy v7 Review Date Jan 2023.pdf		Jan 2023
Relocation Policy (HR014)	Adopted in full HR 014 Policy and Procedure for	Contains details of financial assistance available to staff	March 2025

	Reimbursement of Relocation Expenses V5 Review Date March 2025.pdf	relocating on appointment	
Shared Parental leave procedure (HR 020)	Adopted in full HR 020 – Shared Parental Leave Procedure.pdf		July 2023
Adverse weather policy (HR025)	Adopted with Amendments HR 025 - Adverse Weather & Major Travel Disruption Policy & Procedure.pdf See attached document		Oct 2024
Flexible Working Policy (HR 036)	Adopted in full HR 036 Flexible Working Policy and Procedure V6 Review Date July 2023.pdf		July 2023
Volunteers Policy and Procedure (HR038)	Not adopted		
Ordinary Parental leave policy (HR 044)	Adopted in full HR 044 - Ordinary Parental Leave Policy and Procedure.pdf	Policy contains details of unpaid leave available	Jan 2023
Induction of New employees (HR 054)	Not adopted (CHC local induction)		
Study Leave P&P (HR 058)	Adopted with Amendments HR 058 - Study Leave Policy (applies to all staff apart from Medical & Dental).pdf See attached document	Policy contains details of support in terms of funding and time off for staff undertaking agreed training	Jan 2023
Breastfeeding (HR 063)	Adopted in full HR 063 - Supporting Staff Members to Continue Breastfeeding When They Return to Work.pdf		Sep 2023
Time off for TU duties (HR 065)	Adopted in full HR 065 - Time Off for Recognised Staff Representatives for Trade Union Duties & Activities.pdf	Policy contains detail of when elected reps can take time off from work for TU duties	Jan 2023
Flexi Hours (HR 067)	Adopted in full HR 067 Flexi Hours Policy.pdf	Employees work their total number of contractual hours, but are permitted	Jun 2020

		flexibility as to when they begin and end a day or shift.	
Working time Regs P&P (HR 069)	Adopted in full [HR 069 - Working Time Regulations Policy and Procedure.pdf](#)		Oct 2023
Victims of Domestic Violence (HR 070)	Adopted in full [HR 070 - Domestic Abuse and Sexual Violence Policy.pdf](#)		Oct 2020
Job Evaluation (HR 073)	Adopted in full [HR 073 - Evaluating New Jobs & Re-evaluation of Changed Jobs Policy.pdf](#)		Nov 2020
Fixed terms & temp contracts (HR 076)	Adopted in full [HR 076 - Fixed Term and Temporary Contracts Policy and Procedure V9 Review Date May 2025.pdf](#)		May 2025
Staff with caring responsibilities (HR 077)	Adopted in full [HR 077 - Staff who have Caring Responsibilities Policy.pdf](#)		Apr 2021
Overtime Policy (HR 082)	Adopted in full [HR 082 - Overtime and Hours Over Contract Procedure 1.pdf](#)	Policy sets out provision for exceptional overtime and refers to A4C T&Cs in respect of pay rate applicable	Oct 2021
Retirement Policy (HR 083)	Adopted in full [HR 083 – Retirement Policy and Procedure.pdf](#)	provide staff with information and highlight the options available for staff that wish to change their working arrangements before or after accessing their pension benefits	July 2023
Secondary Employment (HR 096)	Adopted in full [HR 096 - Secondary Employment and Voluntary Emergency Callers Policy & Procedure 1.pdf](#)		Jan 2023
Agile Working Policy (HR 098)	Adopted in full [HR 098 - Agile Working and Flexible Workstyles Policy 1.pdf](#)		Nov 2023

| Injury allowance procedure (HR 099) | Adopted in full [HR 099 - Industrial Injury Allowance Claim Procedure 1.pdf] | This procedure applies to PTHB employees who are claiming that they have **sustained an injury** or **have contracted a disease** or **other health condition on or after 31st March 2013** that they believe is wholly or mainly attributable to their NHS employment and is not due to or aggravated by their own negligence or misconduct. | Oct 2023 |

AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2022-23

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in HM Treasury's Audit and Risk Assurance Committee Handbook (March 2016), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board;
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts;
- ensure compliance with key statutory, national and best practice audit and assurance requirements and reporting arrangements.

Audit, Risk & Assurance Committee
2022-23 Work Programme

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MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Governance & Assurance:								
Approach to 2022-23 Annual Accounts	DF&IT							✓
Annual Accountability Report 2021-22	BS	✓	✓					
Annual Accounts 2021-22, including Letter of Representation	DF&IT	✓	✓					
Annual Governance Programme Reporting	BS	✓		✓		✓		✓
Application of Single Tender Waiver	DF&IT	✓	✓	✓	✓	✓	✓	✓
Audit Recommendation Tracking	BS	✓		✓	✓	✓	✓	✓
Welsh Health Circular Tracking	BS	✓		✓		✓		✓
Risk Management Report	BS					✓	✓	✓
Losses and Special Payments Annual Report 2021-22	DF&IT		✓					
Losses and Special Payments Update report	DF&IT			✓			✓	
Policies Delegated from the Board for Review and Approval	BS/ DF&IT	**As and when identified**						
Register of Interests	BS			✓				✓
Review of Standing Orders	BS	✓						
Community Health Council Transfer	DWOD					✓		
Internal & Capital Audit:								
Head of Internal Audit Opinion 2021-22	HoIA	✓						
Internal Audit Progress Report 2022-23	HoIA	✓	✓	✓	✓	✓	✓	✓
Internal Audit Review Reports	HoIA	**In line with Internal Audit Plan 2022-23**						
Internal Audit Plan 2023-24	HoIA							✓
External Audit:								
External Audit Annual Report 2022	EA						✓	
External Audit of Financial Statements 2021-22	EA		✓					

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MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
External Audit Plan 2022	EA							✓
External Audit Progress Report 2022-23	EA	✓	✓	✓	✓	✓	✓	✓
External Audit Review Reports	EA	In line with External Audit Plan 2022-23						
External Audit Structured Assessment	EA						✓	
Anti-Fraud Culture:								
Bribery Policy	HoLCF			✓				
Counter Fraud Annual Report 2021-22	HoLCF	✓						
Counter Fraud Update	HoLCF			✓			✓	
Counter Fraud Workplan 2023-24	HoLCF							✓
Post Payment Verification Annual Report 2021-22	PPVO		✓					
Post Payment Verification Workplan 2023-24	PPVO							✓
Committee Requirements as set out in Standing Orders								
Annual Review of Committee Terms of Reference 2021-22	BS				✓			
Development of Committee Annual Programme of Business	BS	✓						
Review of Committee Programme of Business	BS		✓	✓	✓	✓	✓	✓
Annual Self-assessment of Committee effectiveness 2022-23	BS						✓	
Committee Annual Report 2022-23	BS							✓
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team						✓		
Internal Audit Team					✓			✓

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MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-2023						
		26 April	06 June	18 July	27 Sept	15 Nov	31 Jan	21 March
Local Counter Fraud Team				✓			✓	
Post Payment Verification Team			✓					

KEY:
BS: Board Secretary
DF&IT: Director of Finance and IT
HoIA: Head of Internal Audit
HoLCF: Head of Local Counter Fraud
EAO: External Audit Officer
PPVO: Post Payment Verification Officer

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