Audit, Risk and Assurance Committee (Annual Report & Accounts)

Tue 16 May 2023, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

ARAC_Agenda_16May23_v5.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 21 March 2023 for approval

Attached *Chair*

ARAC_Item_1.3_Unconfirmed_Minutes_21Mar2023_PH_MT.pdf (9 pages)

1.4. Committee Action Log

Chair

ARAC_Item_1.4_Action log.pdf (1 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATIONS/DECISION

2.1. Application of Single Tender Waiver

Attached *Director of Finance and IT*

ARAC_Item_2.1_Application for Single Tender Waiver May 23.pdf (3 pages)

2.2. Counter Fraud Work Plan 2023-24

Attached *Head of Local Counter Fraud*

ARAC_Item_2.2_Counter Fraud Work Plan 2023-24.pdf (3 pages)
ARAC_Item_2.2a_PTHB Counter Fraud Work Plan 2023-24.pdf (9 pages)

2.3. External Audit Plan 2023-24

Attached *External Audit/Director of Corporate Governance*

ARAC_Item_2.3_3559A2023 Powys THB Detailed Audit Plan 2023.pdf (20 pages)

2.4. Committee Annual Report 2022-23

Attached *Director of Corporate Governance*

ARAC_Item_2.4_Committee Annual Report_Apr23_v2.pdf (13 pages)

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Annual Reporting: • Progress with the Annual Report, including the Financial Statements 2022-23 (Presentation)• Draft Accountability Report 2022-23

To Follow *Director of Finance and IT/Director of Corporate Governance*

- ARAC_Item_3.1a_06 POW Health Board 2022-23 template draft submitted 5-5-23.pdf (75 pages)
- ARAC_Item_3.1b_Draft Accountability Report 2022-23_Cover Paper.pdf (4 pages)
- ARAC_Item_3.1bi_MASTER_ACCOUNTABILITY REPORT_APR23_FOR DRAFT SUBMISSION 12-5-23.pdf (117 pages)

3.2. Internal Audit Progress Report 2022-23

Attached *Head of Internal Audit*

- ARAC_Item_3.2_Internal Audit Progress Report May 23 Cover.pdf (3 pages)
- ARAC_Item_3.2a_Powys ARAC Internal Audit Progress Report May 23.pdf (11 pages)

3.3. Internal Audit Reports: a) Temporary Staffing Unit (Reasonable Assurance)

Attached *Head of Internal Audit*

- ARAC_Item_3.3a_PTHB-2223-03 TSU Final Internal Audit Report.pdf (20 pages)

3.4. Draft Head of Internal Audit Opinion 2022-23

Attached *Head of Internal Audit*

- ARAC_Item_3.4_Powys THB Draft HIA Opinion & Annual Report 22-23 Cover.pdf (3 pages)
- ARAC_Item_3.4a_Powys THB Draft HIA Opinion and Annual Report 22-23.pdf (32 pages)

3.5. External Quality Assessment of Internal Audit

Attached *Head of Internal Audit*

- ARAC_Item_3.5_A&A EQA Report Cover.pdf (3 pages)
- ARAC_Item_3.5a_NWSSP - PSIAS EQA - March 2023.pdf (15 pages)

3.6. External Audit Progress Report 2022-23

Attached *External Audit*

- ARAC_Item_3.6_Audit Wales ARAC Update May 2023.pdf (12 pages)

3.7. Structured Assessment 2022-23

Attached *External Audit/Director of Corporate Governance*

- ARAC_Item_3.7_3560A2023 Powys THB 2022 Structured Assessment Report.pdf (38 pages)

3.8. Counter Fraud Annual Report 2022-23

Attached *Head of Local Counter Fraud*

- ARAC_Item_3.8_Counter Fraud Annual Report 2022-23.pdf (3 pages)
- ARAC_Item_3.8a_PTHB Counter Fraud Annual Report 2022-23.pdf (22 pages)

3.9. Audit Recommendation Tracking

Attached *Director of Corporate Governance*

- ARAC_Item_3.9_Audit Recommendations_Report_May2023.pdf (9 pages)
- ARAC_Item_3.9i_Appendix D - IA recommendations that remain OUTSTANDING.pdf (4 pages)
- ARAC_Item_3.9ii_Appendix E - IA recommendations COMPLETED.pdf (3 pages)
- ARAC_Item_3.9iii_Appendix F - IA recommendations NOT YET DUE for implementation.pdf (2 pages)
- ARAC_Item_3.9iv_Appendix G - EXT AR remain OUTSTANDING.pdf (1 pages)
- ARAC_Item_3.9v_Appendix H - EXT AR NOT YET DUE.pdf (1 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

4.1. Draft Committee Work Programme 2023-24

Attached *Director of Corporate Governance*

ARAC_Item_4.1_ARAC Work Prog 23-24.pdf (3 pages)

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: 11 July 2023

POWYS TEACHING HEALTH BOARD
AUDIT, RISK & ASSURANCE COMMITTEE
TUESDAY 16 May 2023
10:00 – 12:00
VIA MICROSOFT TEAMS

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

AGENDA

Time	Item	Title	Attached /Oral	Presenter
	1	**PRELIMINARY MATTERS**		
10:00	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the Previous Meeting held 21 March 2023	Attached	Chair
	1.4	Audit, Risk & Assurance Committee Action Log	Attached	Chair
	2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
10:10	2.1	Application of Single Tender Waiver	Attached	Director of Finance and IT
10:15	2.2	Counter Fraud Work Plan 2023-24	Attached	Head of Local Counter Fraud
10:20	2.3	External Audit Plan 2023-24	Attached	External Audit/Director of Corporate Governance
10:30	2.4	Committee Annual Report 2022-23	Attached	Director of Corporate Governance
	3	**ITEMS FOR ASSURANCE**		
10:35	3.1	Annual Reporting: • Progress with the Annual Report, including the Financial Statements 2022-23 (Presentation) • Draft Accountability Report 2022-23	Attached	Director of Finance and IT/Director of Corporate Governance
11:15	3.2	Internal Audit Progress Report 2022-23	Attached	Head of Internal Audit

11:20	3.3	Internal Audit Reports: a) Temporary Staffing Unit *(Reasonable Assurance)*		Head of Internal Audit
11:25	3.4	Draft Head of Internal Audit Opinion 2022-23	Attached	Head of Internal Audit
11:30	3.5	External Quality Assessment of Internal Audit	Attached	Head of Internal Audit
11:35	3.6	External Audit Progress Report 2022-23	Attached	External Audit
11:40	3.7	Structured Assessment 2022-23	Attached	External Audit/Director of Corporate Governance
11:50	3.8	Counter Fraud Annual Report 2022-23	Attached	Head of Local Counter Fraud
11:55	3.9	Audit Recommendation Tracking	Attached	Director of Corporate Governance
	4	**ITEMS FOR DISCUSSION**		
	4.1	Draft Committee Work Programme 2023-24	Attached	Director of Corporate Governance
	5	**OTHER MATTERS**		
	5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
12:00	5.2	Any Other Urgent Business	Oral	Chair
	5.3	Date of the Next Meeting: Tuesday 11 July at 10.00, Microsoft Teams		

Key:

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

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

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

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

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 21 MARCH 2023 VIA MICROSOFT TEAMS

Present:

Mark Taylor	Independent Member – Capital and Estates (Committee Chair)
Rhobert Lewis	Independent Member – General
Ronnie Alexander	Independent Member – General
Tony Thomas	Independent Member – Finance

In Attendance:

Pete Hopgood	Director of Finance and IT
Ian Virgil	Head of Internal Audit
Sarah Pritchard	Head of Financial services
Hywel Pullen	Deputy Director of Finance
Mike Jones	External Audit
Bethan Hopkins	External Audit
Alice King	External Audit
Jayne Gibbon	Internal Audit
Melanie Goodman	Interna Audit
Helen Bushell	Director of Corporate Governance and Board Secretary
Amanda Legge	All Wales Post Payment Verification Manager*
Sue Tilman	Post Payment Verification Location Manager*
	*Agenda Item 3.5 only

Observers

Carl Cooper	PTHB Chair

Committee Support

Stella Parry	Interim Corporate Governance Manager

Apologies

Carol Shillabeer	Chief Executive

ARA/22/114	**WELCOME AND APOLOGIES** The Committee Chair welcomed everyone to the meeting and confirmed that a quorum was present. Apologies for absence were noted and recorded as above.
ARA/22/115	**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/22/116	**MINUTES OF THE MEETINGS HELD 31 JANUARY 2023** The minutes of the meetings held on 31 January 2023 were RECEIVED and AGREED as being a true and accurate record.
ARA/22/117	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were discussed.
ARA/22/118	**COMMITTEE ACTION LOG** The Committee received the Action Log and noted that a number of actions had been completed or transferred to other Committees. The following actions were discussed: • ARA/22/104a (Machynlleth Hospital Development): It was suggested that the wording of the action be reviewed to ensure consistency with the minutes of the meeting. The Director of Finance and IT agreed that the action would be reviewed and updated in readiness for the next meeting of the Committee. • ARA/22/104a (Accelerated Sustainable Model): It was noted that the Accelerated Sustainable Model had been deferred from the March Board agenda, therefore the action had been updated to reflect the item would be considered by the relevant Board. It was anticipated that this would be the meeting of the Board due to be held on 24 May 2023.
ARA/22/119	**APPLICATION OF SINGLE TENDER WAIVER** The Head of Financial Services presented the following application for single tender waiver received during the period of 1 January to 28 February 2023:

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223044	QUOTE	Cyted UK Ltd	Analysis and reporting of Cytosponge diagnostic tests	Sole Supplier	17/02/2023	£9,900	6 months	Prospective	A1

The Committee RATIFIED the use of Single Tender Waiver in respect of the single item during the period of 1 January to 28 February 2023.

ARA/22/120

APPROACH TO 2022-23 ANNUAL REPORT AND ANNUAL ACCOUNTS

The Director of Finance and IT presented the item which provided an outline of the approach and principles to be adopted for completion of the 2022/23 Annual Accounts together with the planned approach to key financial areas. It was noted that the development and presentation of the approach was good practice which had been implemented for the previous few years and was supported by Audit Wales.

The Committee NOTED that timescales were due to be extended in comparison to 2021/22 due to an extended audit timeline that has been communicated to all NHS Wales bodies, details of this were due to be considered in more detail under agenda item 2.4 (ARA/22/122). The approach in respect of the following matters was also highlighted to the Committee:

- Revaluations and De Recognitions
- IFRS 16
- Primary Care Accruals

	• Retrospective Continuing Health Care Claims • 6.3% Pension Increase • Scheme Pays • Early Retirement Pension Provision/Permanent Injury Independent Members sought assurance by asking the following questions: *Is there an increased risk of qualifications due to the extension to the timeframe of the Audit Wales audit of the accounts?* The Director of Finance and IT recognised the increased potential for variability in actuals as a result of the extended timeframe however assured the Committee that the methodology and detail behind the production of estimates had been carefully considered. It was also highlighted that the slight increase in risk would be present for all Welsh health boards. The Committee discussed and APPROVED the approach to the Annual Report and Accounts 2023-24.
ARA/22/121	**INTERNAL AUDIT PLAN 2023-24** The Director of Corporate Governance and Board Secretary introduced the item and highlighted that plan had been developed alongside Executive colleagues to ensure a risk based approach. The Head of Internal Audit presented the plan which provided a detailed overview of the proposed audits due to take place in 2023-24 and analysis of the corresponding resource for delivery, appended to the plan was Internal Audit Charter. Appendix A of the plan provided details of the plan, including outline scope for each audit, it was noted that there was a slight reduction in the number of audits since the previous year, from 26 (2022-23) to 24 (2023-24) it was anticipated that this would improve the ability to widen coverage as necessary. Under the approach adopted by Internal Audit for a number of years, the top slice provided to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the health board would need to pay an additional £64,325 (£57,614 in 22/23) to cover this additional audit work, it was noted that any additional audit work required in relation to capital would be incorporated into business cases. Independent Members sought assurance by asking the following questions: *Recognising the iterative nature of the Internal Audit scopes included within the plan, would the Committee be informed of any changes?* It was confirmed that any amendments will be reported via the Internal Audit Progress Report which is a standing item on the Committee's agenda. The Director of Corporate Governance and Board Secretary also highlighted that she would review each scope in an independent capacity which would provide additional corporate assurance. The final scope is also received by the Committee within the final internal audit report.

	The Committee APPROVED the Internal Audit Plan for 2023-24 and the Internal Audit Charter as at March 2023.
ARA/22/122	**EXTERNAL AUDIT PLAN 2023-24** The External Audit, Financial Audit Manager presented the item which set out an outline plan which provided an overview of the external audit team and key dates. It was anticipated that further detail would be presented to the Committee in May. It was highlighted to the Committee that appended to the plan was two letters dated 1 March 2023, the letters detailed the intention for both an increase in fees for the provision of external audit as well as an increase in the length of time required to undertake the audit of the financial accounts. Audit fees were due to increase by 10.2% as a result of ISA 315, in addition to the 4.8% inflationary increase set out in the Audit Wales 2023-24 Fee Scheme and an audit certification deadline of 31 July 2023 was proposed for NHS Wales. It was highlighted that over the coming three years there was a plan established to revert to the 15 June deadline as below: • Audit of Accounts 2022-23 – certification by 31 July 2023; • Audit of Accounts 2023-24 – certification by 30 June 2024; and • Audit of Accounts 2024-25 – certification by 15 June 2025. Independent Members sought assurance by asking the following questions: *Was there any indication that Welsh Government would fund the additional audit costs?* The Director of Finance and IT confirmed that there were no plans for any additional funding at the time of the meeting, therefore the increase in fees would present a cost pressure for the health board. *The increase in fees presented is substantial, is it felt that this is proportionate?* The Director of Finance and IT recognised the reasons presented for the increase in fees, such as the implementation of ISA 315 and acknowledged the broader extent of financial challenge throughout the public sector in Wales and the wider UK. It was highlighted that the health board would need to work closely with audit colleagues throughout the period to ensure a collaborative approach to the pressures within the system. The Director of Corporate Governance agreed that the circumstances presented significant challenge for both organisations and highlighted the plan for a return to business as usual as a positive development. The Committee DISCUSSED and APPROVED the Draft External Audit Plan 2023-24.

ARA/22/123	**INTERNAL AUDIT PROGRESS REPORT 2022-23** The Head of Internal Audit presented the report which provided an overview of the progress against the 2022-23 Internal Audit Plan. The following matters were highlighted for the Committee's attention: • 3 audits had been finalised since the previous meeting of the Committee; • At the time of reporting 2 reports were in draft, 2 audits were work in progress and 4 were at the planning stage; • It was proposed that the COVID-19 Outbreak Control Plan and Contact Tracing audit was removed from the plan as following discussions with Director of Public Health it was felt that the audit was no longer appropriate due to the change in the situation in relation to COVID-19, assurance in relation to the area would be provided as part of the COVID-19/Vaccination audit planned for 2023-24. The Committee DISCUSSED and NOTED the update and APPROVED the removal of the COVID-19 Outbreak Control Plan audit.
ARA/22/124	**INTERNAL AUDIT REPORTS** *a) Therapies and Health Sciences Professional Governance Structure (Reasonable Assurance)* The Head of Internal Audit presented the report which sought to review the controls and processes in place in respect of the implementation of the Therapies and Health Sciences Professional Governance Structure. It was found that The Therapies and Health Sciences Directorate has structures in place within the areas sampled which allows for scientific and therapy staff, professional registrants and practitioners to work within clearly defined professional and clinical governance arrangements. *b) Incident Management (Reasonable Assurance)* The Head of Internal Audit presented the report which sought to review the arrangements in place within the Health Board for the identification, recording, investigation and management of incidents. The Committee received the Internal Audit Reports and took ASSURANCE from their content.
ARA/22/125	**EXTERNAL AUDIT STRUCTURED ASSESSMENT** External Audit provided a verbal update and confirmed that there had been delays with the production of the Structured Assessment, the report had been submitted to health board in draft for checking and was due to be presented to the meeting of the Committee in May. The Director of Corporate Governance reported it was felt that the report was balanced with no areas of concern for the Committee's attention.

	The Committee RECEIVED and NOTED the update.
ARA/22/126	**EXTERNAL AUDIT PROGRESS REPORT 2022-23** External Audit presented the item which provided an update on current and planned Audit Wales work. The Committee NOTED the update: • Orthopaedic services – Follow-up (Published 2 March 2023) • Audit of the 2022-23 Accountability Report and Financial Statements (Planning) • Review of Unscheduled Care (Fieldwork underway) • Workforce Planning (Fieldwork underway) • Structured Assessment (Report in Draft) • Primary Care Services – Follow-up Review (Scoping) Independent Members sought assurance by asking the following questions: *Was it anticipated that there would be a change in scope of the \Primary Care Services Follow-up?* It was confirmed that there were no plans to change the scope of the follow-up from the original review however consideration was due to be given to the wider context e.g. recruitment issues whilst undertaking the follow-up review. The Committee DISCUSSED and NOTED the Report.
ARA/22/127	**POST PAYMENT VERIFICATION (PPV) UPDATE AND WORKPLAN 2023-24** The All Wales Post Payment Verification Manager and Post Payment Verification Location Manager joined the meeting and provided an overview of the overall performance of the health board against the national averages. PPV claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP), it was highlighted that assurance is not provided in relation to General Dental Service (GDS). Independent Members sought assurance by asking the following questions: *The All Wales average claim error rate had increased year on year since 2020/21, was there any concern in relation to this trend?* The All Wales Post Payment Verification Manager highlighted that a higher rate of claim error was expected during revisits as these were focused in areas of concern. The Committee was assured that there was no concern in relation to this trend, which indicated that the revisits were operating as anticipated. The Committee DISCUSSED and NOTED the Report.

ARA/22/128	**AUDIT RECOMMENDATION TRACKING** The Director of Corporate Governance presented the item which provided the 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 31st January 2023. It was reported that significant progress had been made in relation to implementation of recommendations to date with an increased focus on high priority overdue recommendations and impact analysis going forward. Members noted that an increased focus on prioritisation and associated risks would be helpful for the purposes of providing assurance to the Committee. The Head of Internal Audit noted that am internal audit review of the process for manging audit recommendations, including a sample of evidence for closed recommendations was due to be undertaken imminently which would provide the next step in assurance. The Director of Corporate Governance noted that a protocol that outlined the roles of this Committee, the Executive Committee, the Director of Corporate Governance etc. would be included within the update report to the Committee. The Committee CONSIDERED the position and took ASSURANCE that the organisation has an appropriate system for tracking and responding to audit recommendations.
ARA/22/129	**ANNUAL GOVERNANCE PROGRAMME REPORTING** The Director of Corporate Governance presented the item which provided an update on progress against the Annual Governance Programme as of Q3 2022-23. It was noted that the Annual Governance Programme would be reviewed for 2023-24 in line with the Integrated Medium Term Plan 2023-26 and the outcome of the Structured Assessment. The Committee took ASSURANCE from the position reported.
ARA/22/130	**WELSH HEALTH CIRCULAR TRACKING** The Director of Corporate Governance presented the item which provided the Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHCs) and Ministerial Directions. It was highlighted that the single No Progress reported was in relation to recommendations from a WHC in response to a rare disease, for which Powys did not have the necessary speciality clinicians. Work was underway to identify a proportionate and appropriate course of action for Powys. Members suggested that they would be keen to see progress against this item in the next report and it was confirmed that should no progress be reported, the Medical Director would be invited to the Committee to provide an update.

	The Committee DISCUSSED the current position, considering those WHCs where no progress has been made and took ASSURANCE that the organisation is managing Welsh Health Circulars appropriately.
ARA/22/131	**REGISTER OF INTERESTS** The Director of Corporate Governance presented the item which provided the Register of Interests for Board and Executive Members as of 1st March 2023, which would be published to the health Board's website following the Committee. It was noted that further work was underway to include professional registration and extend reporting to Deputy/Assistant Directors and Professional Heads of service. The Committee NOTED the contents of the Register and took ASSURANCE that the organisational policy was being implemented.
ARA/22/132	**REVIEW OF COMMITTEE PROGRAMME OF BUSINESS** The Committee RECEIVED and NOTED the Committee programme of business.
ARA/22/133	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Director of Corporate Governance and Board Secretary wished to highlight to the Board that the Cyber Security Internal Audit Report was to be considered by the Committee in an In-Committee session at the close of the meeting.
ARA/22/134	**ANY OTHER URGENT BUSINESS** No other urgent business was declared.
ARA/22/135	**DATE OF NEXT MEETING** 16 May 2023, 10:00, Microsoft Teams

RAG Status:

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

Audit and Risk Assurance Committee								
Meeting Date	**Item Reference**	**Lead**	**Meeting Item Title**	**Details of Action**	**Update on Progress**	**Original target date**	**Revised Target Date**	**RAG status**
OPEN ACTIONS FOR REVIEW - NONE								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE - NONE								

ACTIONS RECOMMENDED FOR CLOSURE (MEETING 16 MAY 2023)								
31-Jan-23	ARA/22/104b	Director of Strategy, Primary Care and Partnerships	Diagnostic Strategic Intent	Diagnostic Strategic Intent paper to be considered at March 2023 Board as part of the Accelerated Sustainable Model	**16.05.23 update -** ASM is not an agenda item at the March Board but has been added to the work programme, as has the diagnostic strategic intent paper.			Completed

Patterson,Liz
12/05/2023 15:46:31

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Audit, Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**SINGLE TENDER WAIVERS**
Approved and presented by:	Director of Finance, Information and IT
Prepared by:	Head of Financial Services
Other Committees and meetings considered at:	N/A

PURPOSE:

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

RECOMMENDATION(S):

It is recommended that the Audit, Risk and Assurance Committee RATIFIES the use of Single Tender Waiver in respect of three items during the period of 1 March 2023 and 31 March 2023 and consider additional information provided regarding the individual single tender document.

Ratification	Discussion	Information
✓		

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

The previous report on single tender waiver use was received by the Audit Risk and Assurance Committee at its March 2023 meeting which covered the period from 1 January 2023 and 28 February 2023.

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

Single Tender Reference	Request to waive QUOTE or TENDER threshold	Name of Supplier	Item	Reason for Waiver	Date of Approval	Value £	Length of Contract	Prospective/ Retrospective	Appendix Ref
POW2223039	Tender	Arc Orthodontics Ltd	Provision of Orthodontic Treatment	Extension of previous contract as interim measure while formal procurement is undertaken due to clinical need	16/03/2023	£96,451	12 months	Prospective	A1
POW2223040	Tender	Exclusive Orthodontics Ltd	Provision of Orthodontic Treatment	Extension of previous contract as interim measure while formal procurement is undertaken due to clinical need	16/03/2023	£115,125	12 months	Prospective	A2
POW2223040	Tender	Kingsbridge Medical Ltd	Provision of Orthodontic Treatment	Extension of previous contract as interim measure while formal procurement is undertaken due to clinical need	16/03/2023	£200,810	12 months	Prospective	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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

Audit Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**Counter Fraud Work Plan 2023/24**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	

PURPOSE:

The Counter Fraud Work Plan 2023/24 is presented to the Audit Risk & Assurance Committee to seek approval. Planned activity is set out around key areas of work intended to be undertaken by the Local Counter Fraud Specialists during 2023/24 and takes account of the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.

RECOMMENDATION(S):

It is recommended that the Audit Risk & Assurance Committee APPROVE the Counter Fraud Work Plan 2023/24 as presented.

Ratification	Discussion	Information
X		

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

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				

Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

Counter Fraud Work Plan 2023/24

Matthew Evans
Head of Counter Fraud Services

Introduction

Following introduction of new Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/22, the Health Board's Counter Fraud Workplans have been aimed at ensuring compliance for the first enforcement year of the new standards in 2023/24.

Good progress has been made and this is reflected in continuing improvements to RAG ratings for each Standard in self assessed Functional Standard Returns throughout the last two financial years. There are two Standards Components that are still not Green rated however;

- Component 1B - Accountable individual - rated Amber
- Component 3 - Fraud bribery and corruption risk assessment - rated Amber

Work Plan action number 30 sets out proposed activity to uplift Competent 1B and Work Plan action numbers 11 & 12 set out activity to uplift Component 3.

The Health Board contracts Swansea Bay UHB via Service Level Agreement for the provision of Counter Fraud Resource. This results in 1.2 FTE of accredited counter fraud specialist resource supplemented by 0.2 FTE admin support which translate to 308 days deliverable for counter fraud activity.

The Work Plan is set around proactive activity covering Inform & Involve, Prevent & Deter and Strategic Governance as well as reactive activity covered by Hold to Account. The planned days are split as proactive days – 208 and reactive days - 100 days. This is in line with delivery of previous years and takes in to account the commitments made within this Work Plan.

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture in line with GovS 013 component 11. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations as a result of the feedback received. Report outcomes to the Director of Finance.	Throughout the Year
2	Undertake awareness work to highlight the availability of counter fraud awareness training aiming to increase attendance numbers.	Throughout the Year
3	To develop and maintain the counter fraud information contained on the Health Board intranet site, to include details of successfully prosecuted cases – both local and national	Q2 and Q4
4	Ensure that Fraud and Corruption Reporting Line advertising posters are displayed throughout the organisation, publicising the free-phone reporting line number.	Throughout the Year
5	Actively promote and encourage staff awareness and completion of the Counter Fraud E-learning package.	Throughout the Year
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	As Appropriate
7	Design, produce and distribute two counter fraud newsletters annually, containing articles on proven fraud cases (both local and national) and other “beware” notices and relevant messages.	Q2 and Q4

INFORM AND INVOLVE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
8	In conjunction with the Health Board Communications Team, review the strategy in place for raising awareness of economic crime risks and publicise the work of the LCFS, to ensure that it remains fit for purpose and that all appropriate awareness-raising mechanisms are being fully exploited.	Q2
9	In line with GovS 013 Components 4, 7 and 12 undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan; Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Throughout the Year
10	Utilise the finding and results of the fraud risk assessment programme to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	Throughout the Year
	TOTAL DAYS ALLOCATED	**68**

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
10	Review key organisational policies, procedures and documents, to ensure that they are adequately robust to counter fraud. The communication of revised policies, procedures and documents as appropriate, emphasising the organisational commitment to countering fraud.	As Appropriate
11	Carry out risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate in line with GovS 013 component 3.	Throughout the Year
12	Utilise DATIX for recording of risk assessment work to effectively manage, evaluate, evidence and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud in line with GovS 013 component 2, GovS 013 component 3 and GovS 013 component 5.	Throughout the Year
13	Liaise with Corporate Governance colleagues around measuring effectiveness and staff awareness of conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010 in line with GovS 013 component 12.	Q1
14	Review and update information sharing protocols currently in place. Review and refresh protocols with key partners of Internal Audit and Workforce & Organisational Development	Q4
15	Regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance)	Throughout the Year
16	Record and respond to ad-hoc requests for assistance received.	Throughout the Year
17	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	As Appropriate

PREVENT AND DETER		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
18	Issue of fraud alerts to all appropriate staff.	As Appropriate
19	Regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Throughout the Year
20	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Throughout the Year
21	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	As Required
22	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption in line with GovS 013 component 10.	Throughout the Year
23	Membership of Local Intelligence Network and attendance at meetings.	As Required
	TOTAL DAYS ALLOCATED	**100**

HOLD TO ACCOUNT		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
24	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	As Required
25	Appropriate use of the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	As Required
26	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	As Required
27	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	As Required
28	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	As Required
29	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities in line with GovS 013 Component 9.	Q1
30	Explore Memorandum of Understanding between South Wales Police and the Health Board to cover matters of joint interest when undertaking investigation. This will look at joint approach to	
	TOTAL DAYS ALLOCATED	**100**

STRATEGIC GOVERNANCE		
	TASK/OBJECTIVE	**PROPOSED DELIVERY**
29	Attendance at all Fraud Forum meetings held by CFS Wales.	As Required
30	Nominate a Fraud Champion for the Health Board in line with GovS 013 component 1.	Q1
31	Completion and agreement of the annual work plan with Director of Finance in line with GovS 013 component 2.	Q4
32	Completion and agreement of the annual report with Director of Finance	Q1
33	Regular meetings/liaison with Director and/or Assistant Director of Finance	Throughout the Year
34	Preparation for and attendance at Audit Committee meetings.	As Required
35	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Q4 and As Required
36	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	As Required
37	Continuing use of CLUE3 case management system, as mandated by the NHS Counter Fraud Authority. Utilise system to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise in line with GovS 013 component 8.	Throughout the Year
38	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	Throughout the Year
39	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards in line with GovS 013 component 4 and GovS 013 component 7.	Q2
	TOTAL DAYS ALLOCATED	**40**

SUMMARY TOTALS

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	**INFORM AND INVOLVE**	68
B	**PREVENT AND DETER**	100
C	**HOLD TO ACCOUNT**	100
D	**STRATEGIC GOVERNANCE**	40
	TOTAL	**308**

Archwilio Cymru
Audit Wales

Powys Teaching Health Board – Detailed Audit Plan 2023

Audit year: 2022-23

Date issued: May 2023

Document reference: 3559A2023

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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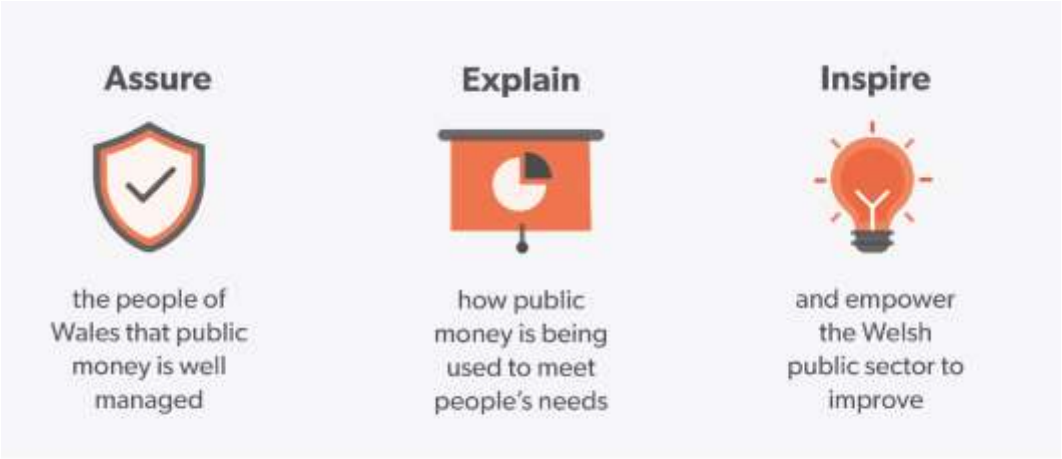
We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

About Audit Wales

Our aims and ambitions



Contents

Introduction

I have now largely completed my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2023.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

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

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

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

My performance audit work is conducted using International Organisation of Supreme Audit Institutions (INTOSAI) auditing standards. INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant financial statement risk

- Risk of management override;
- Risk of the Health Board not meeting its financial duties.

Other areas of audit focus

- Risk of completeness and accuracy of related party transactions;
- Risk of completeness and accuracy of disclosures in the Remuneration Report;
- Risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed.

My performance audit will include:

- Structured Assessment – core
- Structured Assessment – deep dive review of investment in digital
- All-Wales Thematic Review – planned care service recovery
- Local work – to be confirmed

Materiality

Materiality	£3.9 million
Reporting threshold	£0.2 million

Financial statements materiality

Materiality £3.9 million

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- 2021-22 gross expenditure of £398.925 million
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

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

- Remuneration report £1,000
- Related party disclosures for individuals £1,000

Significant financial statements risks

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

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • evaluate the rationale for any significant transactions outside the normal course of business.
There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 12 shows a forecast year-end deficit of £7.5 million. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.	We will focus our testing on areas of the financial statements which could contain reporting bias.

Other areas of focus

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

Exhibit 2: other areas of focus

Audit risk	Our planned response
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert. • test the appropriateness of asset valuation bases. • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts. • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.
There is a risk that the Health Board fails to disclose certain related party transactions and disclosures or discloses these transactions at the incorrect value.	We will review the completeness and accuracy of the disclosures.
There have been historic errors in the Health Board's draft financial statements, when disclosing Senior Officers and Non-Executives Pay within the Remuneration Report.	We will review the completeness and accuracy of the disclosures

Financial statements audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February 2023	March 2023
2023 Detailed Audit Plan	March – May 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements	May – July 2023	July 2023

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Theme	Approach	Key dates
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2023 structured assessment work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2023 with reporting by the end of October 2023.
Structured Assessment - deep dive review of investment in digital	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork to commence during the autumn of 2023 and reporting by April 2024.

Theme	Approach	Key dates
All Wales thematic review of planned care service recovery	I plan to undertake work following on from my national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork to commence between November and December 2023 and reporting by April 2024.
Local project work	Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers.	Fieldwork and reporting timescale to be confirmed.

Fee and audit team

In January 2023 I published the fee scheme for the 2023-24 year as approved by the Senedd Finance Committee. My fee rates for 2023-24 have increased by 4.8% for inflationary pressures. In addition, my financial audit fee has a further increase of 10.2% for the impact of the revised auditing standard ISA315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I estimate your total audit fee will be **£301,850**. A breakdown of the audit fee is set out in **Exhibit 5**.

Our financial audit fee is based on the following assumptions:

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

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2023 (£)[1]	Actual fee for 2022 (£)
Audit of Financial Statements	**£186,539**	**£162,386**
Performance audit work:		
• Structured Assessment	£65,913	£62,945
• All-Wales thematic review	£31,895	£30,332
• Local projects	£17,503	£16,728
Performance audit work total	**£115,311**	**£110,005**
Total audit fee	**£301,850**	**£272,391**

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

[1] The fees shown in this document are exclusive of VAT, which is not charged to you.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Engagement Director/ Audit Director (Performance Audit)	dave.thomas@audit.wales 02920 320604
Derwyn Owen	Audit Director (Financial Audit)	derwyn.owen@audit.wales 02920 320651
Mike Jones	Audit Manager (Financial Audit)	mike.jones@audit.wales 02920 320649
Anne Beegan	Audit Manager (Performance Audit)	anne.beegan@audit.wales 02920 829341
Alice King	Audit Lead (Financial Audit)	alice.king@audit.wales 02920 829353
Bethan Hopkins	Audit Lead (Performance Audit)	bethan.hopkins@audit.wales 02920 829363

I can confirm that my team members are all independent of the Health Board and your officers.

Audit quality

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

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by Quality Assurance Department (QAD)* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

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

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

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

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

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

* QAD is the quality monitoring arm of ICAEW.

Appendix 1

The key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

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Our newsletter provides you with regular updates on our public service audit work, good practice, and events, which can be tailored to your preferences.

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

Agenda item 2.4

AUDIT, RISK AND ASSURANCE COMMITTEE	Date of Meeting: 16 May 2023
Subject:	**AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT TO THE BOARD**
Approved and Presented by:	Director of Corporate Governance / Board Secretary
Prepared by:	Director of Corporate Governance / Board Secretary Interim Corporate Governance Manager
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to provide the Audit, Risk and Assurance Committee Annual Report for 2022/23.

RECOMMENDATION(S):

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

- CONSIDER the Audit and Risk Assurance Committee Annual Report for 2022/23 summarising the key areas of business activity undertaken;
- Take ASSURANCE that the Audit and Risk Assurance Committee is fit for purpose and operating effectively in fulfilling its terms of reference;
- RECOMMEND the report to the Board for the 24 May 2023 meeting.

Approval/Ratification/Decision	Discussion	Information

Contents

1. Introduction

The Audit, Risk and Assurance Committee has been established by the Board in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

This report summarises the key areas of business activity undertaken by the Audit and Risk Assurance Committee ('the Committee') over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

2. Roles and Responsibilities

The Terms of Reference for the Audit and Risk Assurance Committee were reviewed and agreed by the Board in September 2021. The purpose of the Audit and Risk Assurance Committee ("the Committee") is to:

- independently monitor, review and report to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;

- advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;

- Maintain an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Work with the other committees of the Board to provide assurance that governance and risk managements arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

The Committee is responsible for providing advice to the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisations activities;

- the Annual Accountability Report, which includes the Annual Governance Statement;

- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;

- the planned activity and results of internal and external audit;

- adequacy of management response to issues identified by audit activity, including external audit's management letter;

- assurances relating to the management of risk and corporate governance requirements for the organisation;

- systems for financial reporting to the Board (including those of budgetary control);

- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and

- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

It is expected that the Committee will also periodically review its own effectiveness and report the results of that review to the Board.

2.1 Membership of the Committee

The membership of the Committee during 2022/23 was:

Name	Role	Attendance
Tony Thomas	Independent Members (Finance) and Chair of the Committee (March 2022-July 2022)	6/8
Mark Taylor	Independent Members (Finance) and Committee Vice Chair (March 2023-July 2023)/ Chair of the Committee (August 2022 – March 2024)	8/8
Matthew Dorrance	Independent Member (Local Authority)	2/8

	(April 2022 – June 2022)	
Rhobert Lewis	Independent Member (General)	7/8
Ronnie Alexander	Independent Member (General)	6/8
Ian Phillips	Independent Member (ICT)	1/8 (Provided cover for quoracy)

2.2 Others in Attendance

During 2022/23, the following staff attended the Committee:

Name	Role	Attendance
Pete Hopgood	Director of Finance, Information and IT (Joint Executive Lead)	8/8
James Quance	Interim Board Secretary (Joint Executive Lead) (March 2022 – December 2022)	5/8
Helen Bushell	Director of Corporate Governance / Board Secretary (Joint Executive Lead) (January 2023-March 2023)	2/8

Other Directors and officers attended during the year to present reports which related to their areas of responsibility as required.

The Chief Executive, Carol Shillabeer, was also invited to attend every meeting, and attends at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive attended five meetings during the year.

The Chair of the Board, Carl Cooper, attended four meetings. The Chair has a standing invited to attend Board Committees.

Representatives of the Audit Wales, and the Internal Audit Service also attended each meeting.

Representatives of the Counter Fraud Service attended Committee meetings in April 2022, July 2022 and January 2023 to present their reports.

2.3 Meeting frequency

During 2021/22 the Committee met eight times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held no less than quarterly and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business.

One of the eight total meetings is held on an annual basis to receive and Recommend, for Board approval, the Accountability Report and Annual Financial Statements and Accounts.

3. Activity in 2022/23

3.1 Main Areas of Committee Activity 2022/23

Internal Audit	
Internal Audit Reports	Presentation of all Internal Audit Reports, see item 3.2 for more details.
Progress Reports	Internal Audit provided the Committee with regular progress reports against the Internal Audit Plan and monitored progress against recommendations.
Head of Internal Audit Opinion 2021/22	For assurance of the overall assessment and Opinion from the Head of Internal Audit for the 2021/22 year.
Internal Audit Plan 2023-24	Internal Audit presented the Draft Internal Audit Plan for 2023/24 for review, comment and approval.
External Audit	
Progress Reports	Audit Wales provided the Committee with regular progress reports on any external audits and monitored progress against recommendations.
External Audit Reports	Presentation of External Audit Reports, both local and national.
Structured Assessment 2022-23 (Update)	Regular updates reports were provided which reported progress against the development of the Structured Assessment 2022-23.
External Audit Plan 2023-24	External Audit presented Draft External Audit Plan for 2023/24 for review, comment and approval.
Counter Fraud	
Counter Fraud Annual Report 2021-22	Annual Report outlining counter fraud activity in 2021/22 for assurance.

Counter Fraud Updates	Regular updates reporting progress against the workplan and key areas of work undertaken by the Local Counter Fraud Specialists during 2022/23 were provided for assurance.
Corporate Governance	
Audit Recommendation Tracking	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 was provided to each meeting of the Committee for discussion, except for 21 January 2023, and to provide assurance that the organisation has an appropriate system for tracking and responding to audit recommendations.
Welsh Health Circular Tracking	An overview of the position relating to the implementation of Welsh Health Circulars (WHCs) and Ministerial Directions was provided on a quarterly basis for discussion and to provide assurance that the organisation has an appropriate system for tracking and responding to WHCs and Ministerial Directions.
Annual Governance Programme Reporting	Quarterly update regarding progress with the Annual Governance Programme for assurance.
Register of Interests	Register of Interests for Board and Executive Members for discussion and to provide assurance that organisational policy is being implemented..
Committee Work Programme 2022-23	Presented to each Committee for discussion and information.
Local Public Health Team Transfer	An overview of the arrangements that had been put in place to transfer the local public health team function, staff and resources to the Health Board from Public Health Wales, for assurance.

Finance and procurement	
Application of Single Tender Waivers	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 for ratification.
Charitable Funds Annual Report and Accounts 2021-22	Charitable Funds Annual Report and Accounts for the period to 31 March 2021 for the Committee to review, and subsequently consider making the recommendation that the Charitable Funds Committee requests Board approval as Corporate Trustee.
Losses and Special Payments Annual Report 2021-22	Annual Report of Losses and Special Payments for the period 1st April 2021 to 31st March 2022 for assurance.
Losses and Special Payments Interim Report 2022-23	The interim report of Losses and Special Payments for the period 1st April 2022 to 31st October 2022 for assurance.
Post Payment Verification Update and Workplan 2023-24	Update on progress and forward work plan to provide assurance Post Payment Verification cycle is being managed appropriately.
Annual Reporting	
Draft Accountability Report	Draft Annual Accountability Report for 2021-22 for review and comments to inform the final draft.
Draft Financial Accounts	Draft Financial Accounts for 2021-22 for discussion and assurance.
Annual Report and Accounts, 2021-22 including Letter of Representation	Final Draft of the Annual Report and Accounts 2021-22 or consideration prior to being submitted for formal approval at PTHB Board.
Enquiries of Management and Those	Audit Wales Letter formally seeking documented consideration and understanding on a number of governance areas that impact on the audit of financial statements for information.

Charged with Governance	
Approach to the 2022-23 Annual Report and Annual Accounts	Outline of the approach and principles to be adopted for completion of the 2022/23 Annual Accounts together with the planned approach to key financial areas for approval.
Risk Management	
Risk Management Framework	Revised Risk Management Framework for review to ensure that it remains an effective Framework supporting the organisation's risk management arrangements ahead of presentation to the Board for approval.
Risk Appetite Statement	Revised Risk Appetite Statement for review and feedback as part of consultation on the amended approach ahead of presentation to the Board for approval.

3.2 Internal Audit

Summary audits completed 2022/23:

Substantial Assurance	Reasonable Assurance
• Control of Contractors: Follow-up • Looked After Children Health Assessments • Cancer Services - Access to Symptomatic FIT • Women & Children's Services	• Staff Rostering • Security Services • Machynlleth Hospital Reconfiguration Project • North Powys Wellbeing Programme • Charitable Funds • Workforce Futures Strategic Framework • Incident Management • Therapies and Health Sciences Professional Governance Structure • Temporary Staffing Department • Risk Management and Board Assurance Framework (Draft) • Performance Management & Reporting (Draft) • Occupational Health Follow-up (Draft)
Limited Assurance	**Advisory & Non-Opinion**
• IT Infrastructure and Asset Management • Welsh Language Standards • Cyber Security	• Site Leadership & Coordination • Decarbonisation
No Assurance	**Assurance yet to be determined**
N/A	• Savings Plans / Efficiency Framework (WiP) • Follow-up Action Tracker (WiP) • SLAs for IN-reach Medical Staff (WiP)

3.3 Work programme and action log

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This

provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

4. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2022/23, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report or that are already visible in the corporate risk register. The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board.

5. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach and balance the need reduce pressure on staff during this time.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key adaptations made this year included:

- The construct of the Committee meeting agendas remained flexible, and the application of a risk based approach to the selection of agenda items.
- The use of verbal updates and presentations where appropriate to ensure the timeliness of information to the Committee given the fast moving pace of some agenda areas.
- The circulation of relevant material outside meetings where appropriate.

The Committee is in the process of undertaking its annual effectiveness review process.. The outcome and recommendations following this review will be reported to the Board in Quarter 2 of 2023/24.

6. Planned Activity in 2023/24

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme.

POWYS TEACHING HEALTH BOARD

FOREWORD

Statutory background

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Powys Teaching Local Health Board was established under the Local Health Boards (Establishment) (Wales) Order 2003 (S.I. 2003/148 (W.18))

As a statutory body governed by Acts of Parliament the LHB is responsible for :
- agreeing the action which is necessary to improve the health and health care of the population of Powys;
- supporting and financing General Practitioner-led purchasing of the services needed to meet agreed priorities, including charter standards and guarantees;
- supporting and funding the contractor professions;
- the commissioning of health promotion, emergency planning and other regulatory tasks;
- the stewardship of resources including the financial management and monitoring of performance in critical areas;
- eliciting and responding to the views of local people and organisations and changing and developing services at a pace and in ways that they will accept;
- providing Hospital and Community Healthcare Services to the residents of Powys.

Up until 31st March 2023, Powys LHB hosts the Community Health Councils in Wales. In addition, it is also responsible for hosting specific functions in respect of the accounts of the former Health Authorities mostly significantly in respect of clinical negligence. The THB also hosts the functions of Health and Care Research Wales (HCRW).

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2022-23. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.
The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2023

	Note	2022-23 £000	2021-22 £000
Expenditure on Primary Healthcare Services	3.1	**74,960**	72,389
Expenditure on healthcare from other providers	3.2	**201,541**	194,502
Expenditure on Hospital and Community Health Services	3.3	**135,289**	132,034
		411,790	398,925
Less: Miscellaneous Income	4	**(16,094)**	(15,825)
LHB net operating costs before interest and other gains and losses		**395,696**	383,100
Investment Revenue	5	**0**	0
Other (Gains) / Losses	6	**0**	(19)
Finance costs	7	**1**	(60)
Net operating costs for the financial year		**395,697**	**383,021**

See note 2 on page 26 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 74 form part of these accounts.

Other Comprehensive Net Expenditure

	2022-23 £000	2021-22 £000
Net (gain) / loss on revaluation of property, plant and equipment	(2,260)	(3,331)
Net gain/(loss) on revaluation of right of use assets	0	
Net (gain) / loss on revaluation of intangibles	0	0
(Gain) / loss on other reserves	0	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	0	0
Net (gain)/loss on revaluation of financial assets held for sale	0	0
Impairment and reversals	0	0
Transfers between reserves	0	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Other comprehensive net expenditure for the year	(2,260)	(3,331)
Total comprehensive net expenditure for the year	**393,437**	379,690

The notes on pages 8 to 74 form part of these accounts.

Statement of Financial Position as at 31 March 2023

	Notes	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment	11	**103,185**	93,331
Right of Use Assets	11.3	**1,670**	
Intangible assets	12	**0**	0
Trade and other receivables	15	**20**	16,085
Other financial assets	16	**0**	0
Total non-current assets		**104,875**	109,416
Current assets			
Inventories	14	**147**	143
Trade and other receivables	15	**18,134**	11,959
Other financial assets	16	**0**	0
Cash and cash equivalents	17	**1,268**	2,658
		19,549	14,760
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**19,549**	14,760
Total assets		**124,424**	124,176
Current liabilities			
Trade and other payables	18	**(52,318)**	(59,256)
Other financial liabilities	19	**0**	0
Provisions	20	**(12,507)**	(1,301)
Total current liabilities		**(64,825)**	(60,557)
Net current assets/ (liabilities)		**(45,276)**	(45,797)
Non-current liabilities			
Trade and other payables	18	**(508)**	0
Other financial liabilities	19	**0**	0
Provisions	20	**(862)**	(17,085)
Total non-current liabilities		**(1,370)**	(17,085)
Total assets employed		**58,229**	46,534
Financed by :			
Taxpayers' equity			
General Fund		**11,604**	2,153
Revaluation reserve		**46,625**	44,381
Total taxpayers' equity		**58,229**	46,534

The financial statements on pages 2 to 7 were approved by the Board on xx xx 2023 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date:

xx xx xxxx

The notes on pages 8 to 74 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2023

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2022-23			
Balance as at 31 March 2022	2,153	44,381	**46,534**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment	614	0	**614**
Balance at 1 April 2022	2,767	44,381	**47,148**
Net operating cost for the year	(395,697)		**(395,697)**
Net gain/(loss) on revaluation of property, plant and equipment	0	2,260	**2,260**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	16	(16)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	(32)	0	**(32)**
Total recognised income and expense for 2022-23	(395,713)	2,244	**(393,469)**
Net Welsh Government funding	400,275		**400,275**
Notional Welsh Government Funding	4,275		**4,275**
Balance at 31 March 2023	11,604	46,625	**58,229**

The notes on pages 8 to 74 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2022

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2021-22			
Balance at 31 March 2021	(2,532)	41,053	**38,521**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment			
Balance at 1 April 2021	(2,532)	41,053	**38,521**
Net operating cost for the year	(383,021)		**(383,021)**
Net gain/(loss) on revaluation of property, plant and equipment	0	3,331	**3,331**
Net gain/(loss) on revaluation of right of use assets			
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	0	0	**0**
Release of reserves to SoCNE	3	(3)	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2021-22	(383,018)	3,328	**(379,690)**
Net Welsh Government funding	383,639		**383,639**
Notional Welsh Government Funding	4,064		**4,064**
Balance at 31 March 2022	2,153	44,381	**46,534**

The notes on pages 8 to 74 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2023

	Notes	2022-23 £000	2021-22 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(395,697)**	(383,021)
Movements in Working Capital	27	**2,578**	9,755
Other cash flow adjustments	28	**7,228**	12,864
Provisions utilised	20	**(1,761)**	(9,523)
Net cash outflow from operating activities		**(387,652)**	(369,925)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(14,013)**	(13,702)
Proceeds from disposal of property, plant and equipment		**0**	19
Purchase of intangible assets		**0**	0
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(14,013)**	(13,683)
Net cash inflow/(outflow) before financing		**(401,665)**	(383,608)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**400,275**	383,639
Capital receipts surrendered		**0**	0
Capital grants received		**0**	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	0
Capital element of payments in respect of on-SoFP PFI		**0**	0
Capital element of payments in respect of Right of Use Assets		**0**	
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**400,275**	383,639
Net increase/(decrease) in cash and cash equivalents		**(1,390)**	31
Cash and cash equivalents (and bank overdrafts) at 1 April 2022		**2,658**	2,627
Cash and cash equivalents (and bank overdrafts) at 31 March 2023		**1,268**	2,658

The notes on pages 8 to 74 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2022-23 Manual for Accounts. The accounting policies contained in that manual follow the 2022-23 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale,

within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.
The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

List any other transition expedients employed by the entity at its discretion.
Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 20xx will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The entity will not apply IFRS 16 to any new leases of in tangible assets applying the treatment described

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16

The entity is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The entity is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The entity as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset [the entity] applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 The LHB as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of [the entity]'s net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the entitythe LHB's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the NHS Wales organisation has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Wales organisation will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2022-23 and 2021-22. The WRP is hosted by Velindre NHS University Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the NHS Wales organisation assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the NHS Wales organisation becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The NHS Wales organisation accounts for all losses and special payments gross (including assistance from the WRP).

The NHS Wales organisation accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The NHS Wales organisation has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The NHS Wales organisation provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
	Contingent Liability for all other estimated expenditure.	
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of minus 0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Wales organisation therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.2. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.4. Assets contributed by the NHS Wales organisation to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Wales organisation's SoFP.

1.26.5. Other assets contributed by the NHS Wales organisation to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Wales organisation to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Wales organisation, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value. Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.30. Accounting standards issued that have been adopted early

During 2022-23 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the NHS Wales organisation has established that as it is the corporate trustee of the 'Powys Teaching Local Health Board Charitable Fund and other related charities', it is considered for accounting standards compliance to have control of the the 'Powys Teaching Local Health Board Charitable Fund and other related charities'as a subsidiary and therefore is required to consolidate the results of the the 'Powys Teaching Local Health Board Charitable Fund and other related charities' within the statutory accounts of the NHS Wales organisation.

The determination of control is an accounting standard test of control and there has been no change to the operation of the the 'Powys Teaching Local Health Board Charitable Fund and other related charities' or its independence in its management of charitable funds.

However, the NHS Wales organisation has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

	Annual financial performance			
	2020-21	2021-22	2022-23	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	356,471	383,021	395,697	**1,135,189**
Less general ophthalmic services expenditure and other non-cash limited expenditure	1,851	1,355	1,609	**4,815**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Less unfunded revenue consequences of bringing RoU Leases onto SoFP	0	0	0	**0**
Total operating expenses	358,322	384,376	397,306	**1,140,004**
Revenue Resource Allocation	358,465	384,456	390,304	**1,133,225**
Under /(over) spend against Allocation	143	80	(7,002)	**(6,779)**

Powys Teaching Health Board has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23.

The health board did not receive strategic cash support in 2022-23.

2.2 Capital Resource Performance

	2020-21	2021-22	2022-23	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	6,366	15,926	13,211	**35,503**
Add: Losses on disposal of donated assets	0	0	0	**0**
Less NBV of property, plant and equipment and intangible assets disposed	0	0	0	**0**
Less capital grants received	0	0	0	**0**
Less donations received	(13)	0	(527)	**(540)**
Less initial **recognition** of RoU Asset Dilapidations	0	0	0	**0**
Add: recognition of RoU Assets Dilapidations **on crystallisation**	0	0	0	**0**
Charge against Capital Resource Allocation	6,353	15,926	12,684	**34,963**
Capital Resource Allocation	6,380	15,993	12,752	**35,125**
(Over) / Underspend against Capital Resource Allocation	27	67	68	**162**

Powys Teaching Health Board has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2020-21 to 2022-23.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2022-2025 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB submitted an Integrated Medium Term Plan for the period 2022-2025 in accordance with NHS Wales Planning Framework.

The Powys Teaching Health Board submitted a 2022-2025 Integrated Medium Term Plan in accordance with the planning framework

The Minister for Health and Social Services extant approval

Status	**Approved**
Date	July 2022

The LHB has therefore met its statutory duty to have an approved financial plan.

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2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2022-23	2021-22
Total number of non-NHS bills paid	**50,746**	47,474
Total number of non-NHS bills paid within target	**44,751**	41,546
Percentage of non-NHS bills paid within target	88.2%	87.5%

The LHB has not met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2022-23 Total £000	2021-22 Total £000
General Medical Services	40,791		40,791	39,418
Pharmaceutical Services	5,028	(2,529)	2,499	2,621
General Dental Services	8,806		8,806	8,214
General Ophthalmic Services	0	920	920	1,078
Other Primary Health Care expenditure	941		941	1,509
Prescribed drugs and appliances	21,003		21,003	19,549
Total	**76,569**	**(1,609)**	**74,960**	72,389

1. General Medical Services includes £0.527M (£0.636M 2021/22) of staff related costs in respect of a Health Board managed GP Practice. 2. The negative non cash limited balance on Pharmaceutical services relate to prescriptions for Powys residents being dispensed in non Powys pharmacies. The effect of this is a net outflow for Powys LHB.

3.2 Expenditure on healthcare from other providers

	2022-23 £000	2021-22 £000
Goods and services from other NHS Wales Health Boards	**44,679**	44,598
Goods and services from other NHS Wales Trusts	**1,905**	3,592
Goods and services from Welsh Special Health Authorities	**1,051**	277
Goods and services from other non Welsh NHS bodies	**69,733**	67,874
Goods and services from WHSSC / EASC	**50,202**	44,608
Local Authorities	**4,045**	6,564
Voluntary organisations	**2,111**	2,152
NHS Funded Nursing Care	**2,131**	2,149
Continuing Care	**23,667**	20,837
Private providers	**745**	513
Specific projects funded by the Welsh Government	**0**	0
Other	**1,272**	1,338
Total	201,541	194,502

The 7 Health Boards in Wales have established the Welsh Health Specialised Services Committee (WHSSC) which, through the operational management of Cwm Taf Morgannwg University Health Board, secures the provision of highly specialised healthcare for the whole of Wales. These arrangements include funding of services operated through a risk sharing arrangement. The LHB payment for the WHSSC/EASC commissioning arrangements for the year ended 31st March 2023 is £50.203M (2021/22: £44.608M).

The increase in goods and services from other non Welsh NHS bodies results from increased costs for contracts with English NHS providers. The most significant increases are Wye Valley NHS Trust £3.840M in comparison to 2021/22 expenditure. Wolverhampton NHS Foundation Trust also increased by £0.506M in comparison to 2021/22 expenditure.

The decrease in Local Authorities expenditure during 2022/23 is in relation to payments made to jointly deliver the county effort for the Test, Trace and Protect service for Covid 19 of £1.924M (21/22 £4.457M) funded by Welsh Government as per Note 34.2.

The increase in Continuing Health Care expenditure during 2022/23 has resulted from an increase in the number of cases and cost per case compared to 2021/22.

Other Expenditure includes Integrated Care Fund expenditure of £5.084M (2021/22: £4.147M) which aims to drive and enable integrated and collaborative working between social services, health, housing, the third and independent sectors to support underpinning principles of integration and prevention.

Other Expenditure also includes a negative balance which relates to the write back of liabilities from the Statement of Financial Position that have been assessed as no longer payable, which relate to previous years. The 2022/23 value of write backs is more than 2021/22.

3.3 Expenditure on Hospital and Community Health Services

	2022-23	2021-22
	£000	£000
Directors' costs	1,665	1,560
Operational Staff costs	108,361	100,718
Single lead employer Staff Trainee Cost	0	0
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	6,089	5,663
Supplies and services - general	1,407	1,409
Consultancy Services	557	505
Establishment	2,247	1,986
Transport	1,031	1,107
Premises	8,308	8,982
External Contractors	0	0
Depreciation	4,216	4,361
Depreciation (Right of Use assets RoU)	654	
Amortisation	0	0
Fixed asset impairments and reversals (Property, plant & equipment)	1,339	(41)
Fixed asset impairments and reversals (RoU Assets)	0	
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	300	272
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	206	189
Research and Development	0	0
Expense related to short-term leases	0	
Expense related to low-value asset leases (excluding short-term leases)	0	
Other operating expenses	(1,091)	5,323
Total	**135,289**	132,034

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2022-23	2021-22
Increase/(decrease) in provision for future payments:	**£000**	£000
Clinical negligence;		
Secondary care	(3,363)	1,938
Primary care	19	13
Redress Secondary Care	102	2
Redress Primary Care	0	0
Personal injury	136	695
All other losses and special payments	1	38
Defence legal fees and other administrative costs	75	71
Gross increase/(decrease) in provision for future payments	(3,030)	**2,757**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	266	67
Less: income received/due from Welsh Risk Pool	2,970	(2,635)
Total	**206**	189

	2022-23	2021-22
	£	£
Permanent injury included within personal injury £:	(146,835)	(36,697)

The main increases in staff costs relates to £1,400 Pay rise and 1.5% Non Consolidated payment for NHS staff during 2022/23 and the effect of the increase in employer pensions costs payable by 6.3% during the year of £4.254M in comparison to 2021/22 (£4.064M). Full details of the impact of these additional pension costs is provided in detail at note 34.1.

Staff costs also includes an accrual of £1.382M for a consolidated pay increase of 1.5% announced by Welsh Government backdated for 22/23 which will be paid to employees during 2023/24.

Clinical Redress expenditure including defence fees during the year was £0.108M in respect of 31 cases (2021-22 £0.007M in respect of 28 cases). This relates to the movement on provision for claims currently in progress. These are expected to be fully reimbursed by the Welsh Risk Pool should payments be made in respect of the claims. This provision is included within Note 20 of the accounts.

The Movement on Clinical Negligence, Personal Injury and Defence fees links to Note 20 of the accounts and includes the arising in year amounts on these lines offset by the reversed unused amounts of the opening provision.

Increase on line Supplies & Services - Clinical relates mainly to the accounting required for items purchased in respect of the THB renewals programme which aims to implement service provision and improvements to patient treatments post pandemic.

The decrease on line Premises mainly relates to the decrease of costs for providing mass vaccination facilities and decreased digital related spend in comparison to 2021/22.

The decrease in other operating expenses includes a decrease of provision relating to Ex Health Authority early retirement provision of £0.000M (£1.743M 2021/22). The decrease also includes £0.825M decrease in expenditure in comparison to 2021/22 linked to Covid, Increase in dental recharge to General Dental Contract of £1.451M (2021/22: £0.646M) and a negative balance which relates to the write back of liabilities from the Statement of Financial Position that have been assessed as no longer payable, which relate to previous years.

4. Miscellaneous Income

	2022-23 £000	2021-22 £000
Local Health Boards	2,371	2,027
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	51	51
NHS Wales trusts	89	67
Welsh Special Health Authorities	485	0
Foundation Trusts	0	0
Other NHS England bodies	426	312
Other NHS Bodies	0	0
Local authorities	0	0
Welsh Government	3,739	4,797
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	1,065	996
Private patient income	0	0
Overseas patients (non-reciprocal)	0	0
Injury Costs Recovery (ICR) Scheme	33	68
Other income from activities	1,841	1,790
Patient transport services	18	34
Education, training and research	710	2,554
Charitable and other contributions to expenditure	0	0
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	527	0
Receipt of Government granted assets	0	0
Right of Use Grant (Peppercorn Lease)	0	
Non-patient care income generation schemes	0	0
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	1,997	743
Right of Use Asset Sub-leasing rental income	0	
Contingent rental income from finance leases	0	0
Rental income from operating leases	64	71
Other income:		
Provision of laundry, pathology, payroll services	0	0
Accommodation and catering charges	111	101
Mortuary fees	19	16
Staff payments for use of cars	0	0
Business Unit	0	0
Scheme Pays Reimbursement Notional	110	47
Other	2,438	2,151
Total	**16,094**	15,825

Welsh Government miscellaneous income includes funding received on behalf of the hosted function of Health and Care Research Wales within the LHB. This has decreased to £2.657M from an amount of £4.145M received in 21/22.

The decrease in education, training and research income mainly relates to research income received by the LHB hosted function of Health and Care Research Wales of £0.648M (2021/22 £2.591).

Dental fee income has increased in comparison to 2022/23 due to the an increase of volumes of patients treated via the General Dental Services contract in comparison to 2021/22.

The Receipt of Donated Assets of £0.527M relates to contributions from Charitable Organisations to capital schemes. This is further detailed in Note 11.

5. Investment Revenue

	2022-23 £000	2021-22 £000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Total	**0**	0

6. Other gains and losses

	2022-23 £000	2021-22 £000
Gain/(loss) on disposal of property, plant and equipment	0	19
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	**0**	19

7. Finance costs

	2022-23 £000	2021-22 £000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	14	
Interest on obligations under PFI contracts;		
main finance cost	0	0
contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	**14**	0
Provisions unwinding of discount	**(13)**	(60)
Other finance costs	0	0
Total	**1**	(60)

8. Future change to SoCNE/Operating Leases

LHB as lessee

As at 31st March 2023 the LHB had 66 operating leases agreements.

	Post Implementation of IFRS 16		Pre implementation of IFRS 16
Payments recognised as an expense	**Low Value & Short Term**	**Other**	
	2022-23	**2022-23**	2021-22
	£000	**£000**	£000
Minimum lease payments	**0**	**305**	1,035
Contingent rents	**0**	**0**	0
Sub-lease payments	**0**	**0**	0
Total	**0**	**305**	1,035

Total future minimum lease payments			
Payable	**£000**	**£000**	£000
Not later than one year	**0**	**62**	786
Between one and five years	**0**	**18**	650
After 5 years	**0**	**0**	149
Total	**0**	**80**	1,585

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only. Previously reported Expenditure £542k and Minimum lease Payments £1,029k transitioned to the balance sheet as right of use assets.

LHB as lessor

	Post Implementation of IFRS 16	Pre implementation of IFRS 16
Rental revenue	**£000**	£000
Rent	**48**	51
Contingent rents	**0**	0
Total revenue rental	**48**	51

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**48**	48
Between one and five years	**39**	43
After 5 years	**39**	48
Total	**126**	139

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2021-22
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	79,020	632	10,776	0	0	0	90,428	84,438
Social security costs	7,295	0	0	0	0	0	7,295	6,760
Employer contributions to NHS Pension Scheme	13,964	0	0	0	0	0	13,964	13,340
Other pension costs	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	100,279	632	10,776	0	0	0	111,687	104,538

Charged to capital	497	483
Charged to revenue	111,190	104,055
	111,687	104,538
Net movement in accrued employee benefits (untaken staff leave)	0	863
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		863
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave		0

Please detail other staff .

9.2 Average number of employees

	Permanent Staff Number	Staff on Inward Secondment Number	Agency Staff Number	Specialist Trainee (SLE) Number	Collaborative Bank Staff Number	Other Number	Total Number	2021-22 Number
Administrative, clerical and board members	675	6	2	0	0	0	683	652
Medical and dental	30	0	11	0	0	0	41	47
Nursing, midwifery registered	554	1	35	0	0	0	590	597
Professional, Scientific, and technical staff	78	0	10	0	0	0	88	82
Additional Clinical Services	397	0	25	0	0	0	422	402
Allied Health Professions	136	0	7	0	0	0	143	142
Healthcare Scientists	6	0	0	0	0	0	6	5
Estates and Ancilliary	174	0	0	0	0	0	174	176
Students	0	0	0	0	0	0	0	0
Total	2,050	7	90	0	0	0	2,147	2,103

9.3. Retirements due to ill-health

	2022-23	2021-22
Number	5	3
Estimated additional pension costs £	477,190	48,847

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The LHB does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2022-23 Number of compulsory redundancies	2022-23 Number of other departures	2022-23 Total number of exit packages	2022-23 Number of departures where special payments have been made	2021-22 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	1

Exit packages cost band (including any special payment element)	2022-23 Cost of compulsory redundancies	2022-23 Cost of other departures	2022-23 Total cost of exit packages	2022-23 Cost of special element included in exit packages	2021-22 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	6,000
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	6,000

Exit costs paid in year of departure	2022-23 Total paid in year	2021-22 Total paid in year
	£	£
Exit costs paid in year	0	6,000
Total	0	6,000

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

There have been no exit packages in 2022/23

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2022-23	2022-23	2022-23	2021-22	2021-22	2021-22
	£000	£000	£000	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**177**	**25**	**7.1:1**	177	22	8.0:1
Median pay	**177**	**33**	**5.4:1**	177	32	5.5:1
75th percentile pay ratio	**177**	**43**	**4.1:1**	177	41	4.3:1
Salary component of total pay and benefits						
25th percentile pay ratio	**177**	**25**		177	22	
Median pay	**177**	**33**		177	32	
75th percentile pay ratio	**177**	**43**		177	41	

	Highest Paid			Highest Paid		
Total pay and benefits	**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
25th percentile pay ratio	**177**	**25**	**7.1:1**	177	22	8.0:1
Median pay	**177**	**33**	**5.4:1**	177	32	5.5:1
75th percentile pay ratio	**177**	**43**	**4.1:1**	177	41	4.3:1
Salary component of total pay and benefits						
25th percentile pay ratio	**177**	**25**		177	22	
Median pay	**177**	**33**		177	32	
75th percentile pay ratio	**177**	**43**		177	41	

In 2022-23, 2 (2021-22, 2) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £20,758 to £217,294 (2021-22, £18,576 to £188,839).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

9.6.2 Percentage Changes	**2021-22 to 2022-23**	2020-21 to 2021-22
	%	**%**
% Change from previous financial year in respect of Chief Executive		
Salary and allowances	**2**	3
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**2**	3
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**5**	5
Performance pay and bonuses	**0**	0

9.7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2022-2023 tax year (2021-2022 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2022-23	**2022-23**	2021-22	2021-22
NHS	**Number**	**£000**	Number	£000
Total bills paid	1,524	24,182	1,684	164,059
Total bills paid within target	1,015	16,398	1,153	154,222
Percentage of bills paid within target	**66.6%**	**67.8%**	68.5%	94.0%
Non-NHS				
Total bills paid	50,746	123,821	47,474	105,864
Total bills paid within target	44,751	118,997	41,546	101,902
Percentage of bills paid within target	**88.2%**	**96.1%**	87.5%	96.3%
Total				
Total bills paid	**52,270**	**148,003**	49,158	269,923
Total bills paid within target	**45,766**	**135,395**	42,699	256,124
Percentage of bills paid within target	**87.6%**	**91.5%**	86.9%	94.9%

The LHB performance at 88.2% has not met the administrative target of payment 95% of the number of non-nhs creditors paid within 30 days nor did it in 2021/22

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23	2021-22
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	**0**

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	14,377	71,032	722	12,665	8,538	424	7,493	0	115,251
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2022	**14,377**	**71,032**	**722**	**12,665**	**8,538**	**424**	**7,493**	**0**	**115,251**
Indexation	(403)	2,469	49	0	0	0	0	0	2,115
Additions									
- purchased	0	2,643	100	8,642	494	0	743	0	12,622
- donated	0	527	0	0	0	0	0	0	527
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	2,763	299	(3,062)	0	0	0	0	0
Revaluations	(545)	(10,609)	308	0	0	0	0	0	(10,846)
Reversal of impairments	0	1,213	0	0	0	0	0	0	1,213
Impairments	(386)	(2,166)	0	0	0	0	0	0	(2,552)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(507)	0	(2,042)	0	(2,549)
At 31 March 2023	**13,043**	**67,872**	**1,478**	**18,245**	**8,525**	**424**	**6,194**	**0**	**115,781**
Depreciation at 31 March bf	0	11,104	132	0	5,905	284	4,495	0	**21,920**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2022	**0**	**11,104**	**132**	**0**	**5,905**	**284**	**4,495**	**0**	**21,920**
Indexation	0	14	0	0	0	0	0	0	**14**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(10,872)	(133)	0	0	0	0	0	(11,005)
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(507)	0	(2,042)	0	(2,549)
Provided during the year	0	2,479	53	0	788	61	835	0	4,216
At 31 March 2023	**0**	**2,725**	**52**	**0**	**6,186**	**345**	**3,288**	**0**	**12,596**
Net book value at 1 April 2022	**14,377**	**59,928**	**590**	**12,665**	**2,633**	**140**	**2,998**	**0**	**93,331**
Net book value at 31 March 2023	**13,043**	**65,147**	**1,426**	**18,245**	**2,339**	**79**	**2,906**	**0**	**103,185**
Net book value at 31 March 2023 comprises :									
Purchased	13,043	61,952	1,426	18,245	2,302	79	2,906	0	**99,953**
Donated	0	3,195	0	0	37	0	0	0	**3,232**
Government Granted	0	0	0	0	0	0	0	0	**0**
At 31 March 2023	**13,043**	**65,147**	**1,426**	**18,245**	**2,339**	**79**	**2,906**	**0**	**103,185**
Asset financing :									
Owned	13,043	65,147	1,426	18,245	2,339	79	2,906	0	**103,185**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2023	**13,043**	**65,147**	**1,426**	**18,245**	**2,339**	**79**	**2,906**	**0**	**103,185**

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000
Freehold	79,616
Long Leasehold	0
Short Leasehold	0
	79,616

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. **0**

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation h as been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an a rms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2021	14,026	64,084	689	4,745	7,408	424	5,663	0	97,039
Indexation	283	2,454	33	0	0	0	0	0	2,770
Additions									
- purchased	68	3,162	0	9,452	1,414	0	1,830	0	15,926
- donated	0	0	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,532	0	(1,532)	0	0	0	0	0
Revaluations	0	(241)	0	0	0	0	0	0	(241)
Reversal of impairments	0	568	0	0	0	0	0	0	568
Impairments	0	(527)	0	0	0	0	0	0	(527)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(284)	0	0	0	(284)
At 31 March 2022	14,377	71,032	722	12,665	8,538	424	7,493	0	115,251
Depreciation at 1 April 2021	0	9,025	98	0	5,441	223	3,858	0	18,645
Indexation	0	426	5	0	0	0	0	0	431
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(1,233)	0	0	0	0	0	0	(1,233)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(284)	0	0	0	(284)
Provided during the year	0	2,886	29	0	748	61	637	0	4,361
At 31 March 2022	0	11,104	132	0	5,905	284	4,495	0	21,920
Net book value at 1 April 2021	14,026	55,059	591	4,745	1,967	201	1,805	0	78,394
Net book value at 31 March 2022	14,377	59,928	590	12,665	2,633	140	2,998	0	93,331
Net book value at 31 March 2022 comprises :									
Purchased	14,377	57,126	590	12,665	2,557	140	2,998	0	90,453
Donated	0	2,802	0	0	76	0	0	0	2,878
Government Granted	0	0	0	0	0	0	0	0	0
At 31 March 2022	14,377	59,928	590	12,665	2,633	140	2,998	0	93,331
Asset financing :									
Owned	14,377	59,928	590	12,665	2,633	140	2,998	0	93,331
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SoFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2022	14,377	59,928	590	12,665	2,633	140	2,998	0	93,331

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000
Freehold	74,895
Long Leasehold	0
Short Leasehold	0
	74,895

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. 0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

i) Donated Assets
Powys LHB has received the following donated assets during the year. £0.250M from the Iris and Jack Lloyd Memorial Fund £0.150M from the Moondance Foundation and £0.100M from Brecon Hospital League of Friends towards the creation of additional car parking facilities at Brecon War Memorial Hospital. An amount of £0.027M has been recived from Welshpool Hospital League for Friends for the creation of a canopy at the entrance of Victoria War Memorial Hospital.

ii) Valuations
The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

There has also been a valuation of the Car Parking scheme at Brecon War Memorial Hospital upon it being brought into use during the year.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has not been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
There have not been write downs.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are not assets held for sale or sold in the period.

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2022	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2023	0	0	0	0	0	**0**
Balance brought forward 1 April 2021	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2022	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, one is significant in its own right:

Glan Irfon lease held under Land and Buildings - NBV at 31 March 2023 £0.488m

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	**0**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	1796	0	0	466	0	0	0	**2262**
Cost or valuation at 1 April	**0**	**1796**	**0**	**0**	**466**	**0**	**0**	**0**	**2262**
Additions	0	0	0	0	62	0	0	0	**62**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
At 31 March	**0**	**1796**	**0**	**0**	**528**	**0**	**0**	**0**	**2324**
Depreciation at 31 March	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases from PPE Note	0	0	0	0	0	0	0	0	**0**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Recognition	0	0	0	0	0	0	0	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
De-recognition	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	418	0	0	236	0	0	0	**654**
At 31 March	**0**	**418**	**0**	**0**	**236**	**0**	**0**	**0**	**654**
Net book value at 1 April	**0**	**1796**	**0**	**0**	**466**	**0**	**0**	**0**	**2262**
Net book value at 31 March	**0**	**1378**	**0**	**0**	**292**	**0**	**0**	**0**	**1670**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	75	0	0	0	0	0	0	**75**
NHS Wales Market Value Leases	0	815	0	0	292	0	0	0	**1107**
Other Public Sector Peppercorn Leases	0	488	0	0	0	0	0	0	**488**
Other Public Sector Market Value Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**
Private Sector Market Value Leases	0	0	0	0	0	0	0	0	**0**
Total	0	1378	0	0	292	0	0	0	**1670**

11.3 Right of Use Assets continued

Quantitative disclosures

Maturity analysis	
Contractual undiscounted cash flows relating to lease liabilities	**£000**
Less than 1 year	603
2-5 years	508
> 5 years	0
Total	**1111**

Lease Liabilities (net of irrecoverable VAT)	**£000**
Current	603
Non-Current	508
Total	**1111**

Amounts Recognised in Statement of Comprehensive Net Expenditure	**£000**
Depreciation	654
Impairment	0
Variable lease payments not included in lease liabilities - Interest expense	0
Sub-leasing income	0
Expense related to short-term leases	0
Expense related to low-value asset leases (excluding short-term leases)	0

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)	**£000**
Interest expense	14
Repayments of principal on leases	0
Total	**14**

The LHB leases land, buildings and equipment where required to deliver core services.

Where an extension option exists within a lease, the LHB has assessed on an individual contract basis and reflected any extension period within the reported liabilities where it is reasonably certain that the option will be exercised.

12. Intangible non-current assets

2022-23

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2022	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	0	0	0	0	0	0	0
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Gross cost at 31 March 2023	0	0	0	0	0	0	0
Amortisation at 1 April 2022	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0
Amortisation at 31 March 2023	0	0	0	0	0	0	0
Net book value at 1 April 2022	0	0	0	0	0	0	0
Net book value at 31 March 2023	0	0	0	0	0	0	0
NBV at 31 March 2023							
Purchased	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2023	0	0	0	0	0	0	0

12. Intangible non-current assets
2021-22

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	**Total**
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2021	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	**0**
Additions- purchased	0	0	0	0	0	0	**0**
Additions- internally generated	0	0	0	0	0	0	**0**
Additions- donated	0	0	0	0	0	0	**0**
Additions- government granted	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Gross cost at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1 April 2021	**0**	**0**	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	**0**
Impairment	0	0	0	0	0	0	**0**
Provided during the year	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	**0**
Transfers	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	0	0	**0**
Amortisation at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 1 April 2021	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**
NBV at 31 March 2022							
Purchased	0	0	0	0	0	0	**0**
Donated	0	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	0	**0**
Internally generated	0	0	0	0	0	0	**0**
Total at 31 March 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Additional Disclosures re Intangible Assets

The LHB does not hold any Intangible Assets

13 . Impairments

	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000	2021-22 Property, plant & equipment £000	2021-22 Right of Use Assets £000	2021-22 Intangible assets £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0		0
Abandonment in the course of construction	0	0	0	0		0
Over specification of assets (Gold Plating)	0	0	0	0		0
Loss as a result of a catastrophe	0	0	0	0		0
Unforeseen obsolescence	0	0	0	0		0
Changes in market price	0	0	0	0		0
Others (specify)	2,552	0	0	527		0
Reversal of Impairments	(1,213)	0	0	(568)		0
Total of all impairments	1,339	0	0	(41)		0
Analysis of impairments charged to reserves in year :						
Charged to the Statement of Comprehensive Net Expenditure	1,339	0	0	(41)		0
Charged to Revaluation Reserve	0	0	0	0		0
Total	1,339	0	0	(41)		0

There is a reversal of impairment of £0.751M which has occurred as a result of an increase arising on revaluations due to the quinquenniel revaluation exercise and £0.464M for indexation applied during the year that reversed an impairment for the same assets previously recognised as impairments in expenditure. In these cases it is credited to expenditure to the extent of the decrease previously charged there

Within the healthcare segment of the LHB, there are two downward impairments in year totalling £1.011M charged to the statement of Comprehensive Net Expenditure. This includes the downward valuation of £1.011M Land and building assets for which there was insufficient revaluation reserve accumulated at the quinquenniel valuation date . There has also been an impairment of £1.541M as a result of the initial valuation for the bringing into use the enhanced access arrangements and car parking at Brecon War Memorial Hospital
Impairment funding to cover adjustments required is provided to the LHB by Welsh Government on an annual basis.

14.1 Inventories

	31 March 2023 £000	31 March 2022 £000
Drugs	105	99
Consumables	30	24
Energy	4	2
Work in progress	0	0
Other	8	18
Total	**147**	143
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2023 £000	31 March 2022 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	**0**	**0**

15. Trade and other Receivables

Current	31 March 2023 £000	31 March 2022 £000
Welsh Government	148	6,860
WHSSC / EASC	58	539
Welsh Health Boards	605	365
Welsh NHS Trusts	742	612
Welsh Special Health Authorities	178	255
Non - Welsh Trusts	430	241
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	136	47
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	12,752	1,131
NHS Wales Primary Sector FLS Reimbursement	51	24
NHS Wales Redress	185	131
Other	0	0
Local Authorities	838	825
Capital debtors - Tangible	34	7
Capital debtors - Intangible	0	0
Other debtors	1,944	976
Provision for irrecoverable debts	(650)	(383)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	683	329
Other accrued income	0	0
Sub total	**18,134**	11,959
Non-current		
Welsh Government	0	0
WHSSC / EASC	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	0	16,085
NHS Wales Primary Sector FLS Reimbursement	20	0
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Capital debtors - Tangible	0	0
Capital debtors - Intangible	0	0
Other debtors	0	0
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Sub total	**20**	16,085
Total	**18,154**	28,044

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2023 £000	31 March 2022 £000
By up to three months	269	128
By three to six months	129	81
By more than six months	209	364
	607	573

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(383)	(316)
Transfer to other NHS Wales body	0	0
Amount written off during the year	0	0
Amount recovered during the year	58	67
(Increase) / decrease in receivables impaired	(325)	(134)
Bad debts recovered during year	0	0
Balance at 31 March	(650)	(383)

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT

Trade receivables	0	0
Other	0	0
Total	**0**	0

16. Other Financial Assets

	Current		Non-current	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**0**		**0**	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**

17. Cash and cash equivalents

	2022-23 £000	2021-22 £000
Balance at 1 April	**2,658**	2,627
Net change in cash and cash equivalent balances	**(1,390)**	31
Balance at 31 March	**1,268**	2,658
Made up of:		
Cash held at GBS	**1,168**	2,453
Commercial banks	**98**	202
Cash in hand	**0**	3
Cash and cash equivalents as in Statement of Financial Position	**1,266**	2,658
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**2**	0
Cash and cash equivalents as in Statement of Cash Flows	**1,268**	2,658

18. Trade and other payables

Current	**31 March 2023 £000**	31 March 2022 £000
Welsh Government	**1**	0
WHSSC / EASC	**192**	389
Welsh Health Boards	**5,089**	2,649
Welsh NHS Trusts	**469**	772
Welsh Special Health Authorities	**532**	96
Other NHS	**4,184**	2,115
Taxation and social security payable / refunds	**1,044**	108
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**1,225**	1
Non-NHS payables - Revenue	**6,787**	3,803
Local Authorities	**2,716**	5,145
Capital payables- Tangible	**3,829**	4,720
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**603**	
Obligations under finance leases, HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**1,395**	7,826
Non NHS Accruals	**23,769**	29,635
Deferred Income:		
Deferred Income brought forward	**1,997**	743
Deferred Income Additions	**483**	1,997
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**(1,997)**	(743)
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**52,318**	59,256
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**508**	
Obligations under finance leases, HP contracts		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**508**	0
Total	**52,826**	59,256

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The implementation of IFRS 16 on 1st April 2023 has created a requirement for accounting for leases that were previously disclosed as operating leases being reclassified as Right of Use Assets and brought onto Balance Sheet. This has created a requirement for Lease Liability to reflect the payments of the leases in future years. Please see note 11.3 for further details

RoU Lease Liability Transitioning & Transferring	**£000**
RoU Liability as at 31 March 2022	**0**
Transfer of Finance Leases from PPE Note	**0**
Operating Leases Transitioning	**2,262**
RoU Lease liability as at 1 April 2022	**0**
	2,262

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	**31 March 2023 £000**	31 March 2022 £000
Between one and two years	**0**	0
Between two and five years	**0**	0
In five years or more	**0**	0
Sub-total	**0**	0

19. Other financial liabilities

	Current		**Non-current**	
Financial liabilities	**31 March 2023 £000**	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Financial Guarantees:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Derivatives at fair value through SoCNE	**0**	0	**0**	0
Other:				
At amortised cost	**0**	0	**0**	0
At fair value through SoCNE	**0**	0	**0**	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2022	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	123	0	(403)	16,019	34	(501)	(3,397)	0	11,875
Primary care	0	0	0	0	19	(11)	0	0	8
Redress Secondary care	78	0	(14)	0	147	(13)	(45)	0	153
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	996	0	0	83	490	(1,122)	(207)	(13)	227
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	65	0	0	96	77	(90)	(38)		110
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	0
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	39		0	0	95	0	0		134
Total	1,301	0	(417)	16,198	863	(1,738)	(3,687)	(13)	12,507
Non Current									
Clinical negligence:-									
Secondary care	16,019	0	0	(16,019)	0	0	0	0	0
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	921	0	0	(83)	0	0	(147)	0	691
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	98	0	0	(96)	36	(2)	0		36
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	47			0	109	(21)	0	0	135
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	0		0	0	0	0	0		0
Total	17,085	0	0	(16,198)	145	(23)	(147)	0	862
TOTAL									
Clinical negligence:-									
Secondary care	16,142	0	(403)	0	34	(501)	(3,397)	0	11,875
Primary care	0	0	0	0	19	(11)	0	0	8
Redress Secondary care	78	0	(14)	0	147	(13)	(45)	0	153
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	1,917	0	0	0	490	(1,122)	(354)	(13)	918
All other losses and special payments	0	0	0	0	1	(1)	0	0	0
Defence legal fees and other administration	163	0	0	0	113	(92)	(38)		146
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	0			0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	47			0	109	(21)	0	0	135
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	39		0	0	95	0	0		134
Total	18,386	0	(417)	0	1,008	(1,761)	(3,834)	(13)	13,369

Expected timing of cash flows:

	In year to 31 March 2024	Between 1 April 2024 31 March 2028	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	11,875	0	0	11,875
Primary care	8	0	0	8
Redress Secondary care	153	0	0	153
Redress Primary care	0	0	0	0
Personal injury	227	266	425	918
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	110	36	0	146
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0	135	0	135
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	134	0	0	134
Total	12,507	437	425	13,369

The LHB estimates that in 2023/24 it will receive £12.233M and in 2024-25 and beyond £0.020M from the Welsh Risk Pool in respect of Losses and Special Payments.

£11.924M (2021/22: £15.297M) of the provision total relates to the probable liabilities of former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust)

Contingent Liabilities are directly linked to these claims in Note 21.

Also included within 'other' at 31st March 2023 is £0.134M relating to retrospective continuing health care claims (2021/22 £0.039M).

Included within the Redress Secondary Care line and Defence Legal Fees and Other Administration is a provision for expected payments in respect of redress arrangements under National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The amount of Provision in relation to this at 31st March 202 is £0.155M including defence costs (2021/22: £0.078M) and all payments are expected to be fully reimbursed from the Welsh Risk Pool.

There is an amount of £0.156M (2021/22:£0.047M) in respect of 2019-20 Scheme Pays - Reimbursement. The discharge of this provision in future years will be funded by Welsh Government.

20. Provisions (continued)

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	107	0	0	0	168	(72)	(80)	0	**123**
Primary care	0	0	0	0	13	(13)	0	0	**0**
Redress Secondary care	116	0	0	0	47	(40)	(45)	0	**78**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	2,296	0	0	150	867	(2,196)	(111)	(10)	**996**
All other losses and special payments	0	0	0	0	38	(38)	0	0	**0**
Defence legal fees and other administration	126	0	0	9	86	(122)	(34)		**65**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	627			0	0	(627)	0	0	**0**
2019-20 Scheme Pays - Reimbursement	0			0	0	0	0	0	**0**
Restructuring	0			0	0	0	0	0	**0**
Other	64		0	0	20	(34)	(11)		**39**
Total	**3,336**	**0**	**0**	**159**	**1,239**	**(3,142)**	**(281)**	**(10)**	**1,301**
Non Current									
Clinical negligence:-									
Secondary care	14,259	0	0	0	1,850	(90)	0	0	**16,019**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	1,132	0	0	(150)	0	0	(61)	0	**921**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	90	0	0	(9)	37	(2)	(18)		**98**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	4,593			0	1,885	(6,289)	(140)	(49)	**0**
2019-20 Scheme Pays - Reimbursement	0			0	47	0	0	0	**47**
Restructuring	0			0	0	0	0	0	**0**
Other	0		0	0	0	0	0		**0**
Total	**20,074**	**0**	**0**	**(159)**	**3,819**	**(6,381)**	**(219)**	**(49)**	**17,085**
TOTAL									
Clinical negligence:-									
Secondary care	14,366	0	0	0	2,018	(162)	(80)	0	**16,142**
Primary care	0	0	0	0	13	(13)	0	0	**0**
Redress Secondary care	116	0	0	0	47	(40)	(45)	0	**78**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,428	0	0	0	867	(2,196)	(172)	(10)	**1,917**
All other losses and special payments	0	0	0	0	38	(38)	0	0	**0**
Defence legal fees and other administration	216	0	0	0	123	(124)	(52)		**163**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	5,220			0	1,885	(6,916)	(140)	(49)	**0**
2019-20 Scheme Pays - Reimbursement	0			0	47	0	0	0	**47**
Restructuring	0			0	0	0	0	0	**0**
Other	64		0	0	20	(34)	(11)		**39**
Total	**23,410**	**0**	**0**	**0**	**5,058**	**(9,523)**	**(500)**	**(59)**	**18,386**

21. Contingencies

21.1 Contingent liabilities

	2022-23 £'000	2021-22 £'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	11,457	1,059
Primary care	1,628	252
Redress Secondary care	0	0
Redress Primary care	0	0
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	0	0
Continuing Health Care costs	0	0
Other	0	0
Total value of disputed claims	13,085	1,311
Amounts (recovered) in the event of claims being successful	(12,791)	(884)
Net contingent liability	294	427

Legal Claims for alleged medical or employer negligence: £0.221M of the £11.457M relates solely to the former Health Authorities in respect of Medical Negligence and Personal Injury claims for incidents which occurred before the establishment of NHS Trusts (Pre 1996 and Pre 1992 depending on the Trust). £11.236M of the £11.457M relates to Powys LHB cases. Legal advice has established that these claims are not likely to result in payments. In the unlikely event that amounts are payable, all payments over a threshold of £0.025M will be reimbursed to Powys LHB by the Welsh Risk Pool for Powys LHB cases and reimbursed in full for former Health Authority and Primary Care cases.

21.2 Remote Contingent liabilities

	2022-23 £000	2021-22 £000
Guarantees	0	0
Indemnities	0	0
Letters of Comfort	0	0
Total	**0**	**0**

21.3 Contingent assets

	2022-23 £000	2021-22 £000
Please give details	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2022-23 £000	2021-22 £000
Property, plant and equipment	275	8,283
Right of Use Assets	0	
Intangible assets	0	0
Total	**275**	8,283

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2023	
	Number	£
Clinical negligence	51	984,842
Personal injury	63	1,100,722
All other losses and special payments	2	584
Total	116	2,086,148

Analysis of cases in excess of £300,000

	Case Type	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
	CN	MN/030/0623/GAK	332,514	MN/030/0623/GAK	716,642
	CN	MN/030/1441/OF	484,365	MN/030/1441/OF	551,603
	PI			PI/030/1252/HS	346,045
	PI			PI/030/1377/AH	589,917
	PI			PI/030/1467/AH	300,482
	PI			PI/030/1447/AH	310,433
Sub-total		**0**	**816,879**	**0**	**2,815,123**
All other cases		0	1,269,269	0	464,900
Total cases		**0**	**2,086,148**	**0**	**3,280,023**

24. Right of Use / Finance leases obligations

24.1 Obligations (as lessee)

The Local Health Board has no finance leases receivable as a lessee.

Amounts payable under right of use asset / finance leases:	**Post Implementation of IFRS 16 (RoU)**	Pre implementation of IFRS 16 (FL)
Land	**31 March 2023**	31 March 2022
	£000	£000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.1 Right of Use / Finance leases obligations

Buildings	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
	31 March 2023	31 March 2022
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

Other- Non property	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
	31 March 2023	31 March 2022
Minimum lease payments	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

24.2 Right of Use Assets / Finance lease receivables (as lessor)

The Local Health Board has no finance leases receivable as a lessor.

Amounts receivable under right of use assets / finance leases:	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
	31 March 2023	31 March 2022
Gross Investment in leases	**£000**	£000
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Less finance charges allocated to future periods	**0**	0
Present value of minimum lease payments	**0**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**0**	0
	0	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has no PFI Schemes off-statement of financial position.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2023	31 March 2022
	£000	£000
Total payments due within one year	**0**	0
Total payments due between 1 and 5 years	**0**	0
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	0
Total estimated capital value of off-SoFP PFI contracts	**0**	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	**£000**
	0

Contract start date:
Contract end date:

The LHB has no Private Finance Initiatives in operation

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element 31 March 2023 £000	**On SoFP PFI Imputed interest 31 March 2023 £000**	**On SoFP PFI Service charges 31 March 2023 £000**
Total payments due within one year	**0**	**0**	**0**
Total payments due between 1 and 5 years	**0**	**0**	**0**
Total payments due thereafter	**0**	**0**	**0**
Total future payments in relation to PFI contracts	**0**	**0**	**0**

	On SoFP PFI Capital element 31 March 2022 £000	On SoFP PFI Imputed interest 31 March 2022 £000	On SoFP PFI Service charges 31 March 2022 £000
Total payments due within one year	0	0	0
Total payments due between 1 and 5 years	0	0	0
Total payments due thereafter	0	0	0
Total future payments in relation to PFI contracts	0	0	0

	31/03/2023 £000
Total present value of obligations for on-SoFP PFI contracts	**0**

25.3 Charges to expenditure	2022-23	2021-22
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	0	0
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	0	0

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	0	0
Total	0	0

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	0	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

PFI Contract	On/off

25.5 The LHB has no Public Private Partnerships

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2022-23 £000	2021-22 £000
(Increase)/decrease in inventories	(4)	16
(Increase)/decrease in trade and other receivables - non-current	16,065	(1,682)
(Increase)/decrease in trade and other receivables - current	(6,175)	220
Increase/(decrease) in trade and other payables - non-current	508	0
Increase/(decrease) in trade and other payables - current	(6,938)	13,425
Total	3,456	11,979
Adjustment for accrual movements in fixed assets - creditors	891	(2,224)
Adjustment for accrual movements in fixed assets - debtors	(27)	0
Other adjustments	(1,742)	0
	2,578	9,755

28. Other cash flow adjustments

	2022-23 £000	2021-22 £000
Depreciation	4,870	4,361
Amortisation	0	0
(Gains)/Loss on Disposal	0	(19)
Impairments and reversals	1,339	(41)
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	0	0
Government Grant assets received credited to revenue but non-cash	0	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	
Non-cash movements in provisions	(3,256)	4,499
Other movements	4,275	4,064
Total	7,228	12,864

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on xx xxx 2023; post the date the financial statements were certified by the Auditor General for Wales.

On 1st April 2023, the hosted function of Community Health Councils ceased and has been replace by a new body One Voice Wales/Llais. There will be a transfer during 23/24 for any assets and liabilities held in respect of this function at the balance sheet date.

30. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

Related Party	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	7	403,399	1	148
Aneurin Bevan University Health Board	14,754	323	1,827	121
Betsi Cadwaladr University Health Board	4,322	549	626	101
Cardiff & Vale University Health Board	2,405	53	655	28
Cwm Taf Morgannwg University Health Board	5,307	168	134	162
Hywel Dda University Local Health Board	10,049	227	859	22
Public Health Wales NHS Trust	449	1,310	58	191
Swansea Bay University Health Board	10,315	1,481	988	171
Velindre University NHS Trust (inc. WRP)	3,334	1,275	399	1,300
Welsh Ambulance Services Trust	5	45	12	0
Welsh Health Specialised Services Committee (WHSSC)	50,202	104	158	24
Health Education and Improvement Wales (HEIW)	0	1,048	0	151
Digital Health & Care Wales (DHCW)	1,746	524	532	27
Powys County Council	15,481	2,313	2,716	838
NHS Confederation	36	0	0	0
Neath Port Talbot College Group	0	3	0	0
	118,412	**412,822**	**8,965**	**3,284**

Powys LHB has hosted the following functions on behalf of NHS Wales on which it receives income from the Welsh Government and other LHB's:
- Residual Clinical Negligence
- Community Health Councils
- Health and Care Research Wales (HCRW)

Powys LHB also has material transactions with English NHS Trusts with whom it commissions healthcare including:
- Shrewsbury and Telford NHS Trust
- Wye Valley NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Powys LHB has also received items donated from the Powys LHB Charitable Fund, for which the Board is the Corporate Trustee.

A number of the LHB's Board members have interests in related parties as follows:

Name	Details	Interests
Professor Vivienne Harpwood	Chair	Chair of the Welsh NHS Confederation
Professor Vivienne Harpwood	Chair	Independent Member and Trustee of the Central NHS Confederation
Councillor Chris Walsh	Independent Member	Councillor, Powys County Council
Councillor Matthew Dorrance	Independent Member	Councillor, Powys County Council
Ian Phillips	Independent Member	Chair of Welsh Renal Clinical Network (Sub-Committee of WHSSC)
Rhobert Lewis	Independent Member	Chair of Governers, Corporation Board of Neath Port Talbot College Group

31. Third Party assets

The LHB held £160 cash at bank and in hand at 31 March 2023 (31st March 2022, £200) which relates to monies held by the LHB on behalf of patients. This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

None of this cash was held in Patients' Investment Accounts in either 2022-23 or 2021-22.

32. Pooled budgets

A Funded Nursing Care

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the Health Act 1999. The health related function which is subject to these arrangements is the provision of care by a registered nurse in care homes, which is a service provided by the NHS Body under section 2 of the National Health Service Act 1977. In accordance with the Social Care Act 2001 Section 49 care from a registered nurse is funded by the NHS regardless of the setting in which it is delivered. (Circular 12/2003)
The agreement will not affect the liability of the parties for the exercise of their respective statutory functions and obligations. The partnership agreement operates in accordance with the Welsh Government Guidance NHS Funded Nursing Care 2004.

	Funding	Expenditure	Total
	£	£	£
Gross Funding			
Powys Teaching Health Board	*2,108,424*		*2,108,424*
Total Funding	*2,108,424*		*2,108,424*
Expenditure			
Monies spent in accordance with			
Pooled budget arrangement		2,130,956	2,130,956
Total Expenditure		*2,130,956*	*2,130,956*
Net under/(over) spend			*(22,532)*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

B Provision of Community Equipment

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in respect of lead commissioning from a pooled fund for the provision of community equipment in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the host partner for the purposes of the Regulations. The purpose of the agreement is to facilitate the provision of a community equipment service and the development of this service in Powys. The service is provided from a pooled fund and is within the THB's and the Council's powers.

	Funding	Expenditure	Total
	£	£	£
Gross Funding			
Powys County Council	*675,000*		*675,000*
Powys Teaching Health Board	*675,000*		*675,000*
Total Funding	*1,350,000*		*1,350,000*
Expenditure			
Monies spent in accordance with			
Pooled budget arrangement		*1,350,000*	*1,350,000*
Total Expenditure			*1,350,000*
Net under/(over) spend			*0*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

C Provision of Section 33 Joint Agreement for the provision of IT Services

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006.
The agreement will not affect the liability of the parties for the exercise of their respective statutory functions and obligations.
Powys County Council is the lead commissioner and the host partner for the purposes of the regulations.
The purpose of the agreement is to facilitate the provision of ICT services within Powys.

	Funding	Net Expenditure	Total
Gross Funding	£	£	£
Powys County Council	*1,411,720*		*1,411,720*
Powys Teaching Health Board	*839,630*		*839,630*
Total Funding	*2,251,350*		*2,251,350*
Net Expenditure			
Monies spent in accordance with Pooled budget arrangement			
Expenditure		*2,639,132*	*2,639,132*
Income		(465,329)	*(465,329)*
Total Expenditure			*2,173,803*
Net under/(over) spend			*77,547*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

32. Pooled budgets (Continued)

D Provision of Section 33 Joint Agreement for the provision of a Reablement Service

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in respect of lead commissioning from a pooled fund for the provision of an effective and sustainable joint reablement service which meets the needs of the Powys communities in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the host partner for the purposes of the Regulations. This service is provided from a pooled fund and is within the THB's and the Council's powers.

	Funding	Expenditure	Total
	£	£	£
Gross Funding			
Powys County Council	*413,380*		*413,380*
Powys Teaching Health Board	*828,000*		*828,000*
Total Funding	*1,241,380*		*1,241,380*
Expenditure			
Monies spent in accordance with Pooled budget arrangement		*1,273,398*	1,273,398
Total Expenditure		*1,273,398*	*1,273,398*
Net under/(over) spend			*(32,018)*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

E Provision of Section 33 Joint Agreement for the provision of Tier 2/3 Psycho-social Treatment Services

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement in accordance with Section 33 of the National Health Services Act 2006. Powys County Council is the lead commissioner and the host partner for the purposes of the Regulations.
The agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations.
The purpose of the agreement is to provide a Tier 2 and 3 service provision for drug and alcohol users and their concerned others.

	Funding	Expenditure	Total
	£	£	£
Gross Funding			
Powys County Council	*672,808*		*672,808*
Powys Teaching Health Board	*121,864*		*121,864*
Total Funding	*794,672*		*794,672*
Expenditure			
Monies spent in accordance with Joint Arrangement		794,672	794,672
Total Expenditure		*794,672*	*794,672*
Net under/(over) spend			*0*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

F Provision of Section 33 Joint Agreement for the provision of Personal Care at Glan Irfon Integrated Health and Social Care Unit, Builth Wells

Powys Teaching Health Board and Powys County Council have entered into a partnership agreement to enable the use of resources relating to the Inpatient Services at the Glan Irfon Health and Social Centre, Builth Wells.
This agreement will not affect the liability of the parties from the exercise of their respective statutory functions and obligations.

Powys County Council is the lead commissioner and the host partner for the purposes of the Regulations.

The purpose of the agreement is to facilitate the provision of person centred care at Glan Irfon, for 12 residents within the short stay shared care reablement unit with in-reach clinical, nursing and reablement support (registered under CSSIW for Residential Care).

	Funding	Expenditure	Total
	£	£	£
Gross Funding			
Powys County Council	*269,627*		*269,627*
Powys Teaching Health Board	*269,627*		*269,627*
Total Funding	*539,254*		*539,254*
Expenditure			
Monies spent in accordance with Pooled budget arrangement		546,762	546,762
Total Expenditure		*546,762*	*546,762*
Net under/(over) spend			*(7,508)*

The above memorandum account is subject to the audit of the Pooled Budget statements of Powys County Council (the Host).

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

2022/23

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Community Health Councils £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note						
Expenditure on Primary Healthcare Services	3.1	74,960	0	0	0	0	74,960
Expenditure on healthcare from other providers	3.2	200,680	0	0	861	0	201,541
Expenditure on Hospital and Community Health Services	3.3	125,645	25	4,760	4,859	(75)	135,214
		401,285	**25**	**4,760**	**5,720**	**(75)**	**411,715**
Less: Miscellaneous Income	4	10,792	0	0	5,302	(75)	16,019
THB net operating costs before interest and other gains and losses		**390,493**	**25**	**4,760**	**418**	**0**	**395,696**
Investment Income	5	0	0	0	0	0	0
Other (Gains) / Losses	6	0	0	0	0	0	0
Finance costs	7	3	0	(2)	0	0	1
THB Net Operating Costs		**390,496**	**25**	**4,758**	**418**	**0**	**395,697**
Add Non Discretionary Expenditure	3.1	1,609	0	0	0	0	1,609
Revenue Resource Limit	2.1	385,103	25	4,758	418	0	390,304
Under / (over) spend against Revenue Resource Limit		**(7,002)**	**0**	**0**	**0**	**0**	**(7,002)**

2021/22

		Total Total Powys "Health" £'000	Total Residual Clinical Negligence £'000	Total Community Health Councils £'000	Total Health and Care Research Wales (HCRW) £'000	Consolidation Adjustments £'000	Total £'000
	Note						
Expenditure on Primary Healthcare Services	3.1	72,389	0	0	0	0	72,389
Expenditure on healthcare from other providers	3.2	191,784	0	0	2,718	0	194,502
Expenditure on Hospital and Community Health Services	3.3	122,592	25	4,562	4,855	(75)	131,959
		386,765	**25**	**4,562**	**7,573**	**(75)**	**398,850**
Less: Miscellaneous Income	4	8,461	0	0	7,364	(75)	15,750
THB net operating costs before interest and other gains and losses		**378,304**	**25**	**4,562**	**209**	**0**	**383,100**
Investment Income	5	0	0	0	0	0	0
Other (Gains) / Losses	6	(19)	0	0	0	0	(19)
Finance costs	7	(61)	0	1	0	0	(60)
THB Net Operating Costs		**378,224**	**25**	**4,563**	**209**	**0**	**383,021**
Add Non Discretionary Expenditure	3.1	1,355	0	0	0	0	1,355
Revenue Resource Limit	2.1	379,659	25	4,563	209	0	384,456
Under / (over) spend against Revenue Resource Limit		**80**	**0**	**0**	**0**	**0**	**80**

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2022 to 31 March 2023. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2022 and February 2023 alongside Health Board/Trust/SHA data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2022-23
Statement of Comprehensive Net Expenditure for the year ended 31 March 2023	**£000**
Expenditure on Primary Healthcare Services	**76**
Expenditure on Hospital and Community Health Services	**4,178**
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2023	
Net operating cost for the year	**4,254**
Notional Welsh Government Funding	**4,254**
Statement of Cash Flows for year ended 31 March 2023	
Net operating cost for the financial year	**4,254**
Other cash flow adjustments	**4,254**
2.1 Revenue Resource Performance	
Revenue Resource Allocation	**4,254**
3. Analysis of gross operating costs	
3.1 Expenditure on Primary Healthcare Services	
General Medical Services	**0**
General Dental Services	**46**
Other Primary Healthcare Expenditure	**30**
Prescribed Drugs and Appliance	**0**
3.3 Expenditure on Hospital and Community Health Services	
Directors' costs	**66**
Staff costs	**4,188**
9.1 Employee costs	
Permanent Staff	
Employer contributions to NHS Pension Scheme	**4,235**
Charged to capital	**19**
Charged to revenue	**0**
18. Trade and other payables	
Current	
Pensions: staff	**0**
28. Other cash flow adjustments	
Other movements	**4,254**

34. Other Information

34.2 Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales bodies:

	2022-23 £000	2021-22 £000
Capital		
Capital Funding Field Hospitals		0
Capital Funding Equipment & Works		1612
Capital Funding other (Specify)		0
Welsh Government Covid 19 Capital Funding	**0**	**1,612**

Revenue		
Stability Funding	5,747	13,984
Covid Recovery	0	7,578
Cleaning Standards	0	564
PPE (including All Wales Equipment via NWSSP)	0	321
Testing / TTP- Testing & Sampling - Pay & Non Pay	651	1,123
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	2,049	5,150
Extended Flu Vaccination / Vaccination - Extended Flu Programme	345	309
Mass Covid-19 Vaccination / Vaccination - COVID-19	3,552	8,385
Annual Leave Accrual - Increase due to Covid		0
Urgent & Emergency Care		399
Private Providers Adult Care / Support for Adult Social Care Providers		1,470
Hospices		0
Other Mental Health / Mental Health		1,642
Other Primary Care	0	0
Social Care		0
Other	931	0
Welsh Government Covid 19 Revenue Funding	**13,275**	**40,925**

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1b

Audit, Risk and Assurance Committee	**Date of Meeting: 16 May 2023**
Subject :	**Draft Accountability Report Section of the Annual Report 2022/23**
Approved and Presented by:	Director of Corporate Governance / Board Secretary
Prepared by:	Interim Head of Corporate Governance
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this paper is to present the Draft Annual Accountability Report for 2022/23 to the Audit, Risk and Assurance Committee for assurance and to provide an opportunity for feedback.

This report constitutes one component of the larger document that makes up the statutory Annual Report, comprising the Performance Report, Accountability Report and Financial Statements. (The Draft Performance Report is being considered via a separate process, outlined in more detail below).

RECOMMENDATION(S):

The Audit, Risk and Assurance Committee is asked to consider the draft Annual Accountability Report 2022-23 and provide any significant feedback to inform the development of the final draft (noting a final proof read will be undertaken for accuracy and consistency).

Approval/Ratification/Decision[1]	**Discussion**	**Information**
	✓	✓

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

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

EXECUTIVE SUMMARY:

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include: Part 1 The Performance Report, **Part 2 The Accountability Report** (A Corporate Governance Report, A Remuneration and Staff Report, A Parliamentary Accountability and Audit Report), and, Part 3 The Financial Statements.

This report forms the Accountability Report element (Part 2) of the Annual Report and Accounts. The purpose of this element of the Annual Report and Accounts is to meet key accountability requirements set by Parliament. The Draft iteration was submitted to Welsh Government and Audit Wales by Friday 11 May 2023.

Any feedback provided will be incorporated into the development of the final draft, which is due to be considered by the Audit, Risk and Assurance Committee on 11 July 2023 and presented to the PTHB Board for formal approval on 26 July 2023; in readiness for the Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by 31 July 2023.

The Audit, Risk and Assurance Committee is asked to:

- NOTE that the Certificate of the Auditor General for Wales is yet to be issued therefore a holding statement had been provided within the report.
- NOTE that the 2022/23 Chapter 3 Guidance specifically requests that duplication between the Performance Report and Accountability Report is avoided and states that the Performance Report is the primary document (other than for governance, where the Governance Statement is primary). Therefore, there are several sections within the Annual Accountability Report were signposting to the Performance Report has been necessary.

DETAILED BACKGROUND AND ASSESSMENT:

Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them. NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include:

Part 1 The Performance Report, which must include:
- An Overview

Part 2 The Accountability Report, which must include:
- A Corporate Governance Report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report

Part 3 The Financial Statements, which must include:
- The Audited Annual Accounts 2022/23

The 2022/23 Chapter 3 Guidance provides the following reporting timescales:

- Draft Accounts to be submitted to HSSG Finance and Audit Wales Friday 5 May 2023;
- Draft Performance Report Overview, Accountability Report (including the Governance Statement), and Draft Remuneration Report to be submitted to HSSG Finance and Audit Wales by Friday 11 May;
- Final Annual Report and Accounts to be submitted to Audit Wales and HSSG Finance by Monday 31 July 2023, as a single unified PDF document.

The following internal mechanisms have been implemented for the development, approval, and publication of 2022/23 Annual Report and Accounts:

- The Draft Accountability Report was presented to the Executive Committee on 3 May 2023 for review and feedback prior to the draft submission and has been reviewed and cleared by the Director of Corporate Governance and Interim Chief Executive;
- The Draft Performance Report will be subject to review by the Director of Corporate Governance and Interim Chief Executive and shared with the Delivery and Performance Committee for assurance and any significant feedback to inform the development of the final report;
- The Draft Financial Accounts will be presented to the Audit, Risk and Assurance Committee on 16 May 2023 for comments and feedback;
- All three sections will then be combined into a single document, the 'Annual Report and Accounts 2022/23' which will be reviewed by the Audit, Risk and Assurance Committee on 11 July 2023 and presented to the PTHB Board for formal approval on 26 July 2023;
- Subject to approval by the Board the 'Annual Report and Accounts 2022/23' will then be published and presented at the Health Board's Annual General Meeting, due to be held on Wednesday 27 September 2023.

NEXT STEPS:

Any significant feedback on the Draft Accountability Report is welcomed as this will inform the final version of the Accountability Report section of the Annual Report.

The Annual Report and Accounts 2022/23 will continue to be developed to enable submission in line with reporting timescales provided within the 2022/23 Chapter 3 Guidance.

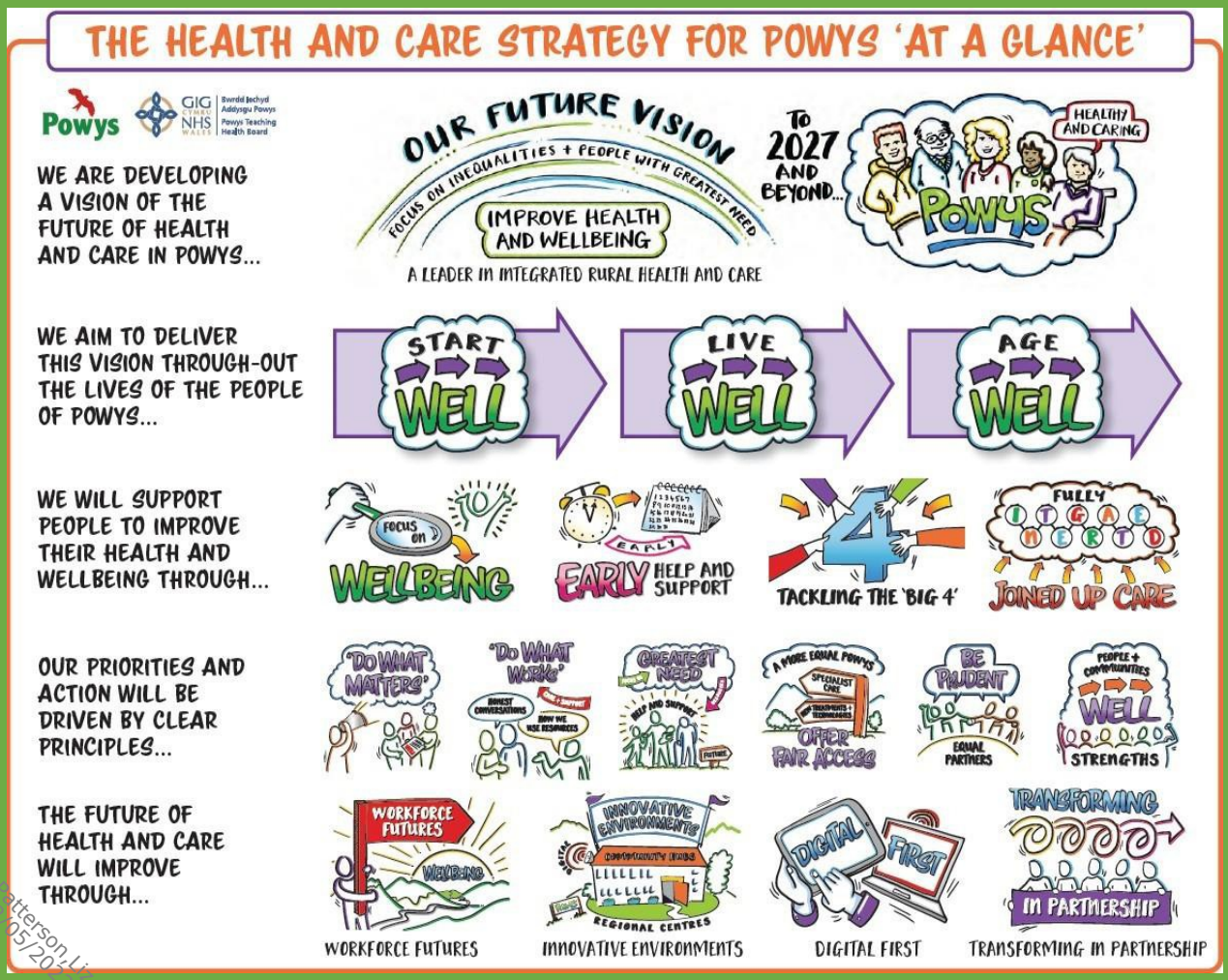
Audit, Risk and Assurance Committee 16 May 2023

Item 3.1bi

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

Annual Report

2022/2023



Contents

SECTION TWO: THE ACCOUNTABILITY REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

THE ACCOUNTABILITY REPORT 2022/2023

SIGNED BY: **DATE: 26 JULY 2023**

HAYLEY THOMAS
[INTERIM CHIEF EXECUTIVE]

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INTRODUCTION TO THE ACCOUNTABILITY REPORT

Powys Teaching Health Board is required, as are all Welsh NHS bodies, to publish an Annual Report and Accounts. Copies of previous years reports are accessible from the Health Board's website.

A key part of the Annual Report is the Accountability Report. The requirements of the Accountability Report are based on the matters required to be dealt with in a Director's Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The requirements of the Companies Act 2006 have been adapted for the public sector context and only need to be followed by entities which are not companies, to the extent that they are incorporated into the Treasury's Government Financial Reporting Manual (FReM) and set out in the 2022/2023 Manual for Accounts for NHS Wales, issued by the Welsh Government.

The Accountability Report is required to have three sections:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report

An overview of the content of each of these three sections is provided below:

The Corporate Governance Report

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2022/2023. It also explains how these governance arrangements supported the achievement of the Health Board's objectives.

The Director of Corporate Governance / Board Secretary has compiled the report, the main document being the Annual Governance Statement. This section of the report has been informed by a review of the work taken forward by the Board and its Committees over the last 12 months and has

had input from the Chief Executive, as Accountable Officer, Board Members and the Audit, Risk and Assurance Committee.

In line with requirements set out in the Companies Act 2006, the Corporate Governance report includes:

- The Director's Report
- A Statement of Accountable Officer Responsibilities
- The Annual Governance Statement

Remuneration and Staff Report

This report contains information about the remuneration of senior management, fair pay ratios and sickness absence rates and has been compiled by the Director of Workforce and Organisational Development, the Director of Finance, IT and Information Services and the Director of Corporate Governance / Board Secretary.

Senedd Cymru/Welsh Parliamentary Accountability and Audit Report

This report contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, and the audit certificate and Auditor General for Wales' Report.

PART A: CORPORATE GOVERNANCE REPORT

This section of the Accountability Report provides an overview of the governance arrangements and structures that were in place across Powys Teaching Health Board during 2022/2023. It includes:

- A Director's Report
- A Statement of Accountable Officer Responsibilities
- A Statement of Executive Directors' Responsibilities in Respect of the Accounts
- The Annual Governance Statement

1. THE DIRECTOR'S REPORT 2022/2023

THE COMPOSITION OF THE BOARD AND MEMBERSHIP

Part 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 sets out the required membership of the Boards of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Powys Teaching Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights. In addition, the Director of Environment and Director of Corporate Governance positions are non-voting Board level posts.

Additionally, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in Schedule 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, and continue to fulfil the relevant requirements throughout the time that they hold office.

The Regulations can be accessed via the Government's legislation website: http://www.legislation.gov.uk/wsi/2009/779/contents/made

VOTING MEMBERS OF THE BOARD DURING 2022/2023

During 2022/2023, the following individuals were voting members of the Board of Powys Teaching Health Board:

Independent Members (IM)		
Vivienne Harpwood	Chair	To 16/09/2022
Carl Cooper	Chair	From 17/09/2022
Kirsty Williams	Vice-Chair	Full Year
Anthony Thomas	IM (Finance)	Full Year
Matthew Dorrance	IM (Local Authority)	To 30/06/2022

Chris Walsh	IM (Local Authority)	From 01/11/2022
Jennifer Owen Adams	IM (Third Sector)	From 30/08/2022
Frances Gerrard	IM (University)	To 30/06/2022
Simon Wright	IM (University)	From 08/08/2022
Ian Phillips	IM (ICT)	Full Year
Cathie Poynton	IM (Trade Union)	Full Year
Mark Taylor	IM (Capital & Estates)	Full Year
Rhobert Lewis	IM (General)	Full Year
Ronnie Alexander	IM (General)	Full Year
Executive Directors		
Carol Shillabeer	Chief Executive	Full Year
Julie Rowles	Executive Director of Workforce and OD	To 03/02/2023 (in post but absent from work resulting in interim cover arrangements as outlined below)
Debra Wood-Lawson	Interim Executive Director of Workforce and Organisational Development	From 03/10/2022
Pete Hopgood	Executive Director of Finance, Information and IT Services	Full Year
Hayley Thomas	Deputy Chief Executive and Interim Executive Director of Primary, Community Care and Mental Health	Full Year
Kate Wright	Executive Medical Director	Full Year
Claire Roche	Executive Director of Nursing and Midwifery	Full Year
Claire Madsen	Executive Director of Therapies and Health Sciences	Full Year
Mererid Bowley	Interim Executive Director of Public Health	From 27/06/2022
Stephen Powell	Interim Executive Director of Planning and Performance	Full Year

During 2022/2023, vacancies in the Board consisted of:

Independent Member	Executive Director
• Independent Member (Local Authority) from 01/07/2022 to 31/10/2022 • Independent Member (Third Sector) from 01/04/2022 to 29/08/2022 • Independent Member (University) from 01/07/2022 to 07/08/2022	• Executive Director of Public Health from 01/04/2022 to 26/06/2022

Whilst a small number of roles on the Board were vacant for short periods, responsibilities were covered by other Board members to ensure continuity of business and effective governance arrangements. Independent Members attended Board Committee meetings where necessary to ensure meetings remained quorate and the Board's duties could be discharged.

The Deputy Director of Workforce and Organisational Development deputised for the Executive Director of Workforce and Organisational Development until the appointment of an Interim Director of Workforce and Organisational Development.

NON-VOTING MEMBERS OF THE BOARD DURING 2022/2023

Jamie Marchant was the Director of Environment (a member of the Executive team and non-voting attendee at Board meetings).

Helen Bushell was appointed to the post of Director of Corporate Governance / Board Secretary on 9 January 2023, (a member of the Executive team and non-voting attendee at Board meetings).

Nina Davies, Interim Director of Social Services, Powys County Council was appointed, by the Minister for Health and Social Services, to the role of Associate Member (non-voting member of the Board) on 1 January 2023.

Further details in relation to role and composition of the Board can be found within the Annual Governance Statement. The Annual Governance Statement also contains further information in respect of the Board and Committee Activity.

AUDIT, RISK AND ASSURANCE COMMITTEE

During 2022/2023, the following individuals were members of the Audit, Risk and Assurance Committee:

Independent Members (IM)		
Anthony Thomas	Committee Chair – IM (Finance) Vice Chair – IM (Finance)	From 01/04/2022 to 18/07/2022 From 19/07/2022
Mark Taylor	Committee Vice-Chair – IM (Capital & Estates) Committee Chair – IM (Capital & Estates)	From 01/04/2022 to 18/07/2022 From 19/07/2022
Matthew Dorrance	IM (Local Authority)	From 01/04/2022 to 30/06/2022
Rhobert Lewis	IM (General)	Full Year
Ronnie Alexander	IM (General)	Full Year
Executive Team Officers by Attendance Only		
Carol Shillabeer	Chief Executive	Full Year
Pete Hopgood	Executive Director of Finance and IT	Full Year
James Quance	Interim Board Secretary	From 01/04/2022 to 31/12/2022
Helen Bushell	Director of Corporate Governance / Board Secretary	From 09/01/2023

DECLARATION OF INTERESTS

Details of company Directorships and other significant interests held by members and attendees of the Board which may conflict with their responsibilities are maintained and updated on a regular basis. A register of Interests is available on the Health Board's website, or a hard copy can be obtained from the Director of Corporate Governance / Board Secretary on request.

PERSONAL DATA RELATED INCIDENTS

Information on personal data related incidents formally reported to the Information Commissioner's office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed within the Annual Governance Statement on page 19.

ENVIRONMENTAL, SOCIAL AND COMMUNITY ISSUES

A statement regarding the Health Board's actions in relation to environmental issues is provided on page 75 of the Accountability Report. Reference to social and community issues can be found on page 7 of the Performance Report in relation to the North Powys Wellbeing Programme.

STATEMENT OF PUBLIC SECTOR INFORMATION HOLDERS

As the Accountable Officer of Powys Teaching Health Board and in line with the disclosure requirements set out by the Welsh Government and HM Treasury, I confirm that the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the year.

Please note Carol Shillabeer was seconded to Betsi Cadwaladr University Health Board from the 3 May 2023 so whilst the Chief Executive Officer (and Accountable Officer) for the 2022/2023 year, at the time of submitting and then signing these statements, Hayley Thomas was the Chief Executive Officer.

SIGNED BY: **DATE: 26 JULY 2023**

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HAYLEY THOMAS

[INTERIM CHIEF EXECUTIVE]

2. STATEMENT OF ACCOUNTABLE OFFICER RESPONSIBILITIES: 2022/2023

STATEMENT OF MY CHIEF EXECUTIVE RESPONSIBILITIES AS ACCOUNTABLE OFFICER OF POWYS TEACHING HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive, should be the Accountable Officer of Powys Teaching Health Board.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as the Accountable Officer.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which Powys Teaching Health Board's auditors are unaware. I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Powys Teaching Health Board's auditors are aware of that information.
- Powys Teaching Health Board's Annual Report and Accounts as a whole is fair, balanced, and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.
- I am responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

SIGNED BY: **DATE: 26 JULY 2023**

HAYLEY THOMAS
[INTERIM CHIEF EXECUTIVE]

Patterson.Liz
12/05/2023 15:46:31

3. STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2022/2023

STATEMENT OF EXECUTIVE DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2022/2023

The Executive Directors of Powys Teaching Health Board are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts the Executive Directors are required to:

- apply accounting principles on a consistent basis, that are laid down by the Welsh Ministers with the approval of the Treasury;
- make judgements and estimates that are responsible and prudent; and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

On behalf of the Executive Directors of Powys Teaching Health Board we confirm:

- that we have complied with the above requirements in preparing the 2022/2023 accounts: and
- that we are clear of our responsibilities in relation to keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the authority, and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction by the Welsh Ministers.

By order of the Board

SIGNED BY: **DATE: 26 JULY 2023**

CARL COOPER [CHAIR]

SIGNED BY: **DATE: 26 JULY 2023**

HAYLEY THOMAS [INTERIM CHIEF EXECUTIVE]

SIGNED BY: **DATE: 26 JULY 2023**

PETE HOPGOOD [INTERIM DEPUTY CHIEF EXECUTIVE, EXECUTIVE DIRECTOR OF FINANCE, IT AND INFORMATION SERVICES]

4. ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

The Board is accountable for Governance, Risk Management, and Internal Control. As Chief Executive of the Health Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated, and assurance has been sought and provided. Additional information is provided in the Governance Statement where necessary. However, the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

I am held to account for my performance by the Chair of the Board and the Chief Executive and Accounting Officer for the NHS in Wales. I have formal performance meetings with both the Chair and the Chief Executive of NHS Wales. Further, the Executive Team of the Health Board meet with the senior leaders of the Department of Health and Social Services on a regular basis.

During 2022/2023, the Health Board and the NHS in Wales continued to face substantial pressure in planning and responding to COVID-19 as well as recovering from the impacts of the pandemic. 2022/2023 was seen as a period to transition from COVID-19 arrangements to business as usual. Internal escalated governance arrangements were put in place between 7 December 2022 and 1 March 2023 in response to winter system resilience including industrial workforce action. Outside formal meetings Board Members remained fully informed receiving briefings at Board Development or Board briefing sessions. Further detail on maintaining good governance during 2022/2023 is provided within this Annual Governance Statement.

FUNCTIONS HOSTED BY POWYS TEACHING HEALTH BOARD

In compliance with requests made by the Welsh Ministers, the Health Board hosts the following functions:

- **The seven Community Health Councils that operate across Wales and the Board of Community Health Councils in Wales:** The Community Health Councils operate across Wales and provide help and advice if citizens have problems with, or complaints about, NHS services. They ensure that citizens' views and needs influence the policies and plans put in place by health providers in their area. They monitor the quality of NHS services from a citizen's perspective and provide information about access to the NHS. The Board of Community Health Councils in Wales was established in April 2004 with the aim to advise, assist and monitor the Community Health Councils with respect to the performance of their functions, and to represent their collective views and interests to the Welsh Ministers.

  In 2015, the regulations were revised, and it was clearly stated that the Board had responsibility of setting standards and to monitor the performance of the Community Health Councils, the conduct of members and performance of officers as well as operating a Complaints Procedure.

  Under the Health and Social Care (Quality and Engagement Act) (Wales) 2020, a new all Wales body, the Citizen's Voice Body, known as Llais, will replace the CHCs as of 1 April 2023. This therefore means the Health Board will no longer host the CHCs (or the new Citizens Voice Body) with effect from 1 April 2023.

- **Health and Care Research Wales (HCRW):** HCRW is a national, multi-faceted, virtual organisation funded and overseen by the Welsh Government's Division for Social Care and Health Research. It provides an infrastructure to support and increase capacity in research and development, runs a number of funding schemes, and manages the NHS research and development funding allocation in Wales. Its aim is to generate and support excellent research to improve the health and care of people in Wales across a range of conditions and settings.

The Board of PTHB is not responsible for the delivery of the objectives of these functions, or their day-to-day management. However, it is responsible for ensuring that the functions are staffed using appropriate recruitment mechanisms, and that PTHB's Standing Financial Instructions and Workforce and Organisational Development policies are complied with.

The Health Board has nominated its Executive Director of Workforce and Organisational Development as the Lead Executive Director for these functions. Key officers from Finance, IT, Governance and Workforce teams have been identified to provide support to the functions, as appropriate.

During 2022/2023 we continued to work with Welsh Government to strengthen the governance and accountability arrangements for the functions that we host, and on the transfer of the CHC to the Citizens Voice Body.

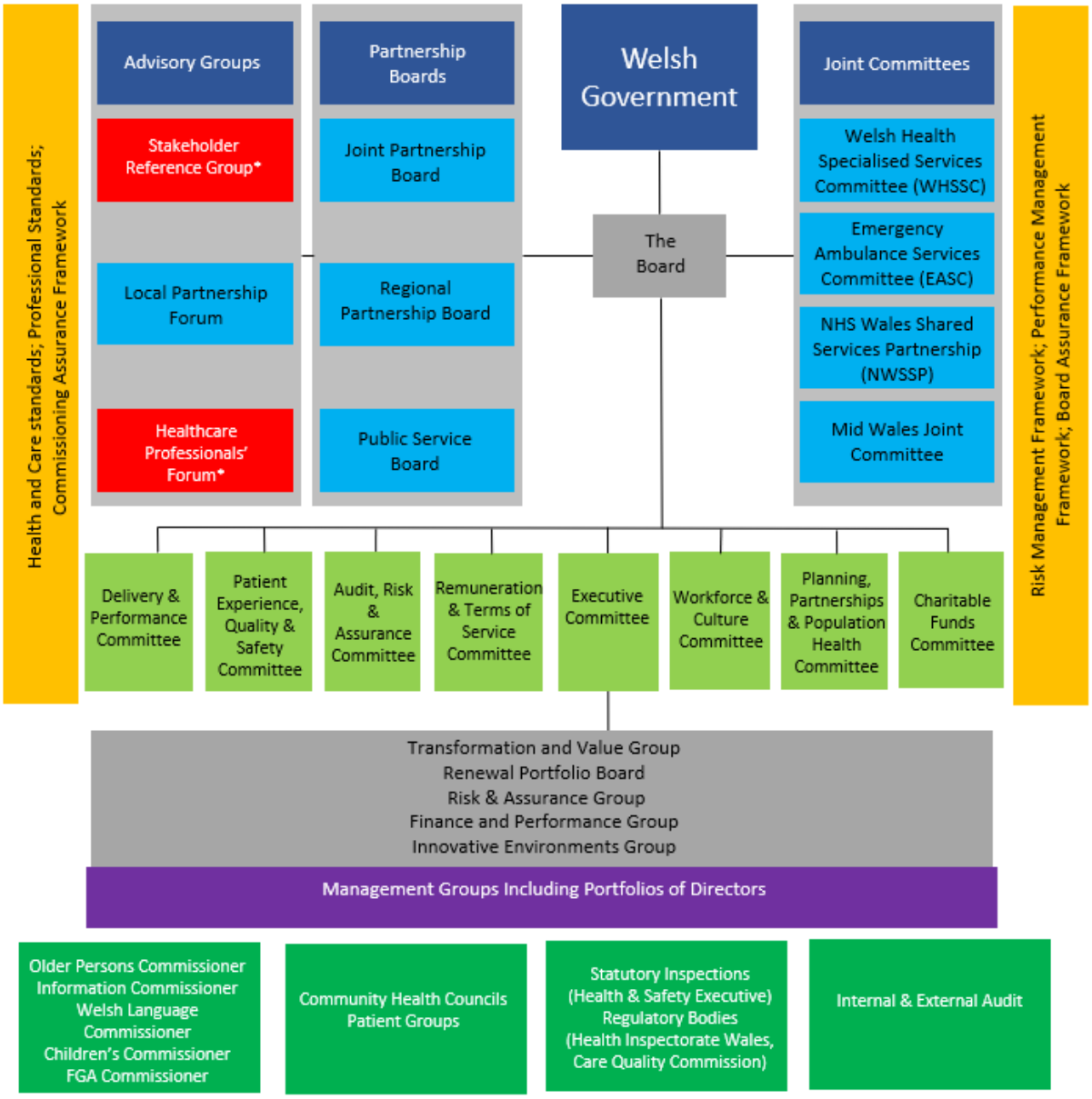
OUR GOVERNANCE AND ASSURANCE FRAMEWORKS

Powys Teaching Health Board has a clear purpose from which its strategic aims and objectives have been developed. Our vision is to enable a 'Healthy Caring Powys'. The Board is accountable for setting the organisation's strategic direction, ensuring that effective governance and risk management arrangements are in place and holding Executive Directors to account for the effective delivery of its three year Integrated Medium Term Plan (IMTP) and related Annual Delivery Plan. A copy of our Integrated Medium-Term Plan for 2022-2025 can be found on the Health Board website.

The Board keeps its governance and assurance frameworks under review. Current arrangements have been in place since July 2021.

Figure 1 on the page that follows provides an overview of the governance frameworks that were in operation during 2022/2023:

Powys Teaching Health Board
Governance and Assurance Framework



** Yet to be established*

THE BOARD

The Board has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board. Details of those who sit on the Board are published on the Health Board website. Further information is also provided within the Director's Report.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation, and I, as the Chief Executive and Accountable Officer, am responsible for maintaining appropriate governance structures and procedures. In summary, the Board:

- sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- establishes and maintains high standards of Corporate Governance;
- sets the risk appetite for the organisation and provides oversight of strategic risks;
- ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- monitors progress against the delivery of strategic and annual objectives; and
- ensures effective financial stewardship by effective administration and economic use of resources.

STANDARDS OF BEHAVIOUR

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

The Board is strongly committed to the Health Board being value-driven, rooted in 'Nolan' principles and high standards of public and behaviour including openness, customer service standards, diversity and engaged leadership. The Board has in place a Standards of Behaviour Policy, which sets out the Board's expectations and provides guidance so that individuals are supported in delivering that requirement.

The Standards of Behaviour Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board's Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles, and responsibilities of those employed by the Health Board, and the arrangements for ensuring that declarations of interests, gifts, hospitality and sponsorship can be made. The policy also aims to capture public acceptability of behaviours of those working in the public sector in order that the Health Board can be seen to have exemplary practice in this regard.

Details of the Board's Standards of Behaviour Policy incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship, is available on the Health Board's website.

STANDING ORDERS AND SCHEME OF RESERVATION AND DELEGATION

The Health Board's governance and assurance arrangements have been aligned to the requirements set out in the Welsh Government's Governance e-manual and the Citizen Centred Governance Principles. Care has been taken to ensure that governance arrangements also reflect the requirements set out in HM Treasury's 'Corporate Governance in Central Government Departments: Code of Good Practice 2017.

The Board has approved Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice. Together with the adoption of a scheme of matters reserved for the Board, a detailed scheme of delegation to officers and Standing Financial conduct of the Health Board and define "its ways of working". The Standing Orders in place during 2022-2023 were adopted by the Board on 27 November 2019, with minor amendments adopted at Board on 28 July 2021 and 25 May 2022, and are available on the Health Board's website.

The Board, subject to any directions that may be made by the Welsh Ministers, is required to make appropriate arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Committee structure is outlined in the following section and the Terms of Reference are available on the Health Board's website.

COMMITTEES OF THE BOARD

Section 3 of Powys Teaching Health Board's Standing Orders provides that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions."*

In line with these requirements the Board has established a standing Committee structure, which it has determined best meets the needs of the Health Board, while taking account of any regulatory or Welsh Government requirements. Each Committee is chaired by an Independent Member of the Board, with the exception of the Executive Committee which is chaired by the Chief Executive as Accountable Officer and is constituted to comply with Welsh Government's Good Practice Guide – Effective Board Committees. All Committees regularly review their Terms of Reference and Work Plans to support the Board's business. Committees also work together on behalf of the Board to ensure that work is planned cohesively and focusses on matters of greatest risk that would prevent the Health Board from meeting its vision, aims and objectives.

As part of the regular review of Board arrangements changes to the Committee structure were agreed at Board on 28 July 2021 and Terms of Reference for each Committee were agreed at Board on 29 September 2021. The following Committee structure is in place:

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

The detailed Terms of Reference, agendas and papers for each of the current Committees can be found on the Health Board's website.

The Chair of each Committee reports the business of each meeting to the Board on the committee's activities and any matters of concern or escalation to be brought to the attention of the Board, through a Chair's report. This contributes to the Board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. Annual reports will be prepared for individual committees after year-end.

The Board and Committee Effectiveness review was undertaken in a Board Development session. The review involved a survey of all Board members and the Board considered arrangements to be appropriate. Decision logs for Board and committees are maintained and used to inform the summary of Board and committee business. Decisions are recorded within minutes which are reported at the following Board or committee meeting.

With the limitations on public gatherings introduced early in the pandemic the Health Board moved to holding Board and Committee meetings virtually, via electronic means. This is not in accordance with the Public Bodies (Admissions to Meetings) Act 1960 whereby the organisation is required to hold its meetings in public. The Health Board is committed to openness and transparency and conducts as much of its Board and Committee business as possible in a session that members of the public are normally welcome to attend and observe, either via a livestream (Board meetings), or by inviting members of the public to contact the Director of Corporate Governance to request arrangements be made for an opportunity to observe Committee meetings which are not livestreamed. The following notice is included in each Committee agenda:

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

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

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

These arrangements have continued in relation to Health Board committee meetings throughout the year. It is acknowledged that Standing Orders have not been fully complied with in terms of access to Board Committee meetings. However, the arrangements outlined above have been put in place to mitigate for this and are in the public interest.

The format and method of holding Board meetings continues to be under frequent review.

Figures 2 below provide an overview of the role and responsibilities of the Board's Committees, as set out within respective Terms of Reference.

Figure 3 below provides an overview of Board and Committee meetings held during 2022/2023.

FIGURE 2: ROLES AND RESPONSIBILITIES OF COMMITTEES OF THE BOARD FROM APRIL 2022 – MARCH 2023

Board

Audit, Risk and Assurance Committee

- Corporate Governance
- Risk Management
- Audit Recommendations
- Counter Fraud
- Post Payment
- Verification
- Anti-Fraud Policies
- Internal Audit
- External Audit
- Probity
- Annual Accountability
- Report
- Accounting Policies
- Board Assurance Framework
- Regulatory Compliance

Workforce and Culture Committee

- Organisational Development Framework
- Workforce Futures
- Strategic Equality Plan
- Staff engagement and voice
- Compassionate leadership
- Learning
- Equality and Diversity
- Welsh Language
- Staff Wellbeing
- Staff raising concerns/whistleblowing.
- Dignity at work
- Respect and resolution
- Recruitment and retention
- Talent management
- Succession planning
- Powys Health and care Academy

Patient Experience, Quality and Safety Committee

- Clinical Leadership
- Putting Things Right
- Serious Incidents and Concerns
- Patient Safety Notices and Alerts
- Infection Prevention and Control
- Patient Experience Strategy
- Patient Feedback
- Clinical Audit
- Improvement Programme
- Quality Performance
- Measures Reporting
- Mental Health
- Safeguarding
- Medical Devices
- Point of Care testing
- Inspection and Regulation

Charitable Funds Committee

- Charitable Funds Income and Expenditure
- Charitable Funds
- Applications
- Probity Regulatory Compliance

Planning, Partnerships and Public Health Committee

- Health and Care Strategy
- Strategic Commissioning Framework
- Enabling Strategic Frameworks
- Monitor and scruntinise major plans including capital schemes.
- Business Continuity Plans
- Powys Public Service Board
- Powys Regional Partnership Board
- Collaborative Working
- Population/wellbeing Assessments
- Plans for promoting.
- Health and Wellbeing

Remuneration and Terms of Service Committee

- Pay, Terms and Conditions of Services for Chief Executive, Executive Directors and very senior members of staff not covered by Agenda for change.
- Objectives and performance monitoring and Executive Directors Performance management system for those mentioned above and its application.
- Approvals of applications under Voluntary Release
- Scheme and redundancies
- Additional Payments to consultants
- Corporate policies related to remuneration and terms of service.

Delivery and Performance Committee

- Performance
- Management Framework Commissioning
- Assurance Framework
- Digital First
- Innovative Environments
- Financial management
- And finance performance
- Strategic priorities
- Directly provided and commissioned services
- Capital Programme
- Estate's compliance
- Health and Safety
- Fire Safety
- Information Governance
- Services delivered by NWSSP

FIGURE 3: BOARD AND COMMITTEE MEETINGS HELD DURING 2022/2023

Board/ Committee	Dates											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Board	28	25 & 31	14	27		28		30		25		29
Audit Risk and Assurance	26	17	13	18		27		15		31		21
Charitable Funds	26		14			23			07	16		01
Delivery and Performance		03	23			12		11			28	
Patient Experience Quality and Safety		12		07		13		24			23	
Planning, Partnerships and Population Health	07			14			20			19		
Remuneration and Terms of service		12		28		26			05	31		06 & 29
Workforce and Culture	31					20			13			~~14~~*

*It should be noted that it was necessary to cancel the March meeting of Workforce and Culture Committee in 2022/2023 at short notice and it was not possible to rearrange the meeting before the end of the corporate year. The Workforce and Culture Committee have thus not complied with the requirement to meet quarterly during this period. To avoid a long gap between meetings of the Committee, the first meeting of the Committee in 2023/2024 has been brought forward by a month whereafter the normal quarterly cycle will resume.

Details of Board Members and their attendance at the Board can be found at **Appendix 1** on page 85.

ITEMS CONSIDERED BY THE BOARD IN 2022/2023

During 2022/2023 the Board held:

- eight public meetings, all virtual, livestreamed and video uploaded after the meeting;
- four In-Committee (private) meetings;
- an Annual General Meeting;
- one Chair's Action;
- two Board Briefings; and
- six Board development sessions.

All meetings of the Board held in 2022/2023 were appropriately constituted with the required quorum.

Board Activity:

During the year, the Board considered a number of key issues and took action where appropriate, these are summarised below:

Standing Items:

- Experience Stories (patient and staff)
- Report of Chair
- Report of Vice-Chair
- Report of CEO
- Minutes from previous meetings
- Performance Reports on:
    - the three year Integrated Medium Term Plan;
    - the one year Delivery Plan; and
    - Financial Performance
- Corporate Risk Register
- Assurance Reports from:
    - Board Committees
    - Joint Committees
    - Partnerships
    - Advisory Group
- Report from Chief Officer of Community Health Council

Board approved the following items:

- Charitable Funds Annual Report and Accounts 2020/2021

- General Medical Services Out of Hours
- Population Needs Assessment
- Scheme of Delegation and Reservation of Powers
- Annual Accountability Report
- Letter of Representation
- Welsh Language Standards Annual Monitoring Report 2021/2022
- Equality, Diversity and Inclusion Annual Report 2021/2022
- Annual Report on Civil Contingencies
- Integrated Performance Framework
- Section 28A agreements
- Covid-19 Public Inquiry (module roles)
- Charitable Funds Strategy
- Management of Policies, Procedures and Written Control Documents
- Risk Management Framework and Risk Appetite Statement
- Winter Resilience Report
- Charitable Funds Annual Report and Annual Accounts 2022/2023
- Integrated Plan 2023-2026
- New Velindre Cancer Centre Full Business Case

Board noted the following items:

- Wellbeing Assessments;
- Report of sealed documents;
- Annual Financial Statements
- Winter Planning

Board considered the following items:

- Renewal Priority – Breathe Well
- Health Wales Whole System Approach to Obesity Prevention
- Renewal Priority – Cancer Programme
- Health Inequalities Report
- Digital First Overview Report

ITEMS CONSIDERED BY COMMITTEES OF THE BOARD

During 2022/2023, Board Committees considered and scrutinised a range of reports and issues relevant to the matters delegated to them by the Board. Reports considered by the Committees included a range of internal audit reports, external audit reports and reports from other review and regulatory bodies, such as Healthcare Inspectorate Wales and the Health and Safety Executive.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in my assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms.

The Committees also considered and advised on areas of local and national strategic developments and new policy areas. Board Members are also involved in a range of other activities on behalf of the Board, such as Board Development sessions, attending partnership meetings, shadowing and a range of other internal and external meetings.

An overview of the key areas of business of the Board committees is set out in **Figure 4**:

Figure 4: Key Areas of Focus of Committees of the Board (in summary)

Audit, Risk and Assurance Committee	▪ ratified approval of Single Tender Waivers ▪ received the Internal Audit Annual Report and Opinion ▪ approved the Annual Internal Audit Plan ▪ received Internal and External Audit Reports and tracked implementation of audit recommendations ▪ received Counter Fraud updates and reports ▪ tracked implementation of Welsh Health Circulars ▪ kept under review the Health Board's arrangements for risk management and assurance ▪ reviewed and sought assurance on the accuracy of the Annual accounts and Annual accountability statement ▪ reviewed and sought assurance on the Charitable Funds Annual report and accounts ▪ reviewed and sought assurance on the accuracy of annual reports ▪ received Annual Register of Interests ▪ reviewed and sought assurance on the Annual Governance Programme ▪ reviewed and sought assurance on losses and special payments
Executive Committee	▪ provided advice to the Board in relation to the development of the Integrated Plan for 2023-2026 ▪ reviewed and provided advice to the Board in relation to the identification and management of corporate risks ▪ reviewed and sought assurance in relation to limited and no assurance internal and external audit reports ▪ received various service-based business cases, service, and improvement plans, making decisions relevant to operational delivery of the Boards strategy and in-year plan ▪ took forward actions arising from the Integrated Performance Report and performance managing the delivery of those action plans ▪ kept the operational effectiveness of policies and procedures under review.

	▪ scrutinised key reports and strategies prior to their submission to other Committees of the Board and/or the Board to ensure their accuracy and quality ▪ provided a strategic view of issues of concern ensuring co-ordination between Executive Directorates ▪ provided advice to the Committees of the Board and/or the Board on matters related to quality, safety, planning, commissioning, service level agreements and change management initiatives ▪ ensured staff are kept up to date on Health Board wide issues ▪ acted as the forum in which Executive Directors and senior managers can formally raise concerns and issues for discussion, making decisions on these issues
Charitable Funds Committee	▪ scrutinised applications for charitable funds ▪ kept an overview of charitable funds income and expenditure ▪ reviewed and recommended to the Board the Charity's Annual report and Annual accounts
Delivery and Performance Committee	▪ sought assurance on performance on the Integrated Medium Term Plan and Delivery Plan ▪ reviewed the Performance section of the Annual Report ▪ sought assurance on financial performance, closely scrutinising areas of cost pressure and savings plans ▪ scrutinised primary care performance (General Medical Services, General Dental Services, Community Pharmacy and Out of Hours) ▪ reviewed Digital First Updates ▪ reviewed Innovative Environments updates, including seeking assurance on Health and Safety matters ▪ sought assurance on the Information Governance and Records Management Improvement plans ▪ reviewed Strategic Renewal Portfolio priorities including Value Based Healthcare, Children and Young People, Urgent and Emergency Care and Community Model ▪ sought assurance on the Committee based Corporate Risk Register

Patient Experience, Quality and Safety Committee	▪ scrutinised the Integrated Quality Report including: o implementation of the Quality and Engagement Act o scrutinise Commissioning Escalation Report o monitor Incidents and Concerns o monitor the Inspections and External Bodies Report and Action Tracking o sought assurance on patient experience o sought assurance on Infection, Prevention and Control including nosocomial updates ▪ monitored Maternity Services Assurance reports including local escalation and de-escalation of Maternity Services ▪ received the Annual Reports of the Accountable Officer Controlled Drugs ▪ monitored compliance with Mental Health legislation ▪ scrutinised the Board's Clinical Quality Framework ▪ sought assurance on the Committee based Corporate Risk Register
Planning, Partnerships and Population Health Committee	▪ reviewed the strategic change report ▪ reviewed development of the Integrated Plan ▪ sought assurance on the Regional Partnership Board programmes ▪ sought assurance on the Wellbeing Assessment and Population Assessment ▪ monitored primary care cluster planning ▪ sought assurance on Smoke Free Premises and Vehicles compliance ▪ sought assurance on the Covid-19 Vaccination Programme 2022/2023 ▪ sought assurance on the delivery of Multi-Agency Plan for ALN and Education Tribunal (Wales) Act 2018 ▪ sought assurance on the Tobacco control Delivery Plan ▪ sought assurance on the Healthy Schools and Healthy Preschools schemes ▪ approved the Healthy Wales Whole System Approach to Obesity Prevention ▪ sought assurance on the Committee based Corporate Risk Register

Workforce and Culture Committee	▪ scrutinised the Workforce Performance Reports ▪ scrutinised the Equality, Diversity and Inclusion monitoring report ▪ sought assurance on Workforce Futures: o Carers and Volunteers) o Workforce and Planning o Education and Training o Leadership and Team Development o Intensive Learning Academy ▪ sought assurance and on the Communications and Engagement six month report ▪ reviewed the implementation of agile working and new ways of working ▪ sought assurance on staff wellbeing ▪ received the Welsh Language Standards Annual Report 2020/2021 ▪ considered Staff Wellbeing including regulatory report and management response (Caring for the Carers) ▪ received the Medical Job Planning Annual Report ▪ received the Communications and Engagement Situation Report ▪ sought assurance on the Committee based Corporate Risk Register

BOARD DEVELOPMENT

During the year, the Board took part in a number of development and briefing sessions which covered the following topics:

- Board and Committee Effectiveness (2021/2022)
- Discussion on learning from significant reviews
- Climate and carbon
- Procurement Training
- Charities Governance and Strategy
- Development of The Board
- Risk identification and Risk Registers
- Review of Board level frameworks
- Integrated Medium Term Planning
- Financial Planning
- Accelerated Sustainable Model development
- Duty of Quality and Duty of Candour

The Board has scheduled its annual self-assessment and reflection for 2022/2023 to take place in quarter 1 of 2023 (to include consideration of the effectiveness of its committees).

ADVISORY GROUPS

PTHB's Standing Orders require the Board to have three advisory groups in place. When active, these allow the Board to seek advice from and consult with staff and key stakeholders. They are:

- a Stakeholder Reference Group;
- a Local Partnership Forum; and
- a Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board website.

The Local Partnership Forum (LPF) is well established. Work has continued during 2022/2023 to strengthen the Forum's operating arrangements and maximise its role in providing advice to the Board.

The Standing Orders require the Health Board to constitute a Stakeholder Reference Group and Healthcare Professionals Forum. System pressures have meant that progress was not made to constitute these groups during 2022/2023. The Health Board therefore declares a non-compliance with our Standing Orders in so far as these two forums are concerned.

In the absence of the Healthcare Professionals Forum, the Board engages clinical professionals through its clinical Executive Directors (Executive Medical Director, Executive Director of Nursing and Midwifery, Executive Director of Therapies and Health Sciences and Executive Director of Public Health) and existing management groups such as the Heads of Nursing and Midwifery Group and the Heads of Therapies. The Health Board also engages with GPs through its cluster arrangements, other primary care contractors through established forums and with many representative and regulatory bodies.

In the absence of the Stakeholder Reference Group the Board engages with partners and stakeholders through robust local partnership arrangements which make best use of the coterminous relationship between the Health Board, Local Authority and third sector umbrella body, PAVO. This includes the Powys Public Service Board, Powys Joint Partnership Board (Health Board and Local Authority) and Powys Regional Partnership Board.

The Regional Partnership Board has well established engagement mechanisms to inform an integrated health and care agenda, with user voice and stakeholder engagement networks in place. The RPB's Engagement and Insight Network also brings together engagement officers from across partner organisations to ensure a co-ordinated and collaborative approach to community engagement that puts the citizen at its heart, as evidence through a joined-up engagement approach to inform the develop of well-being and population assessments, and the area plan and well-being plan. Constructive relationships have also been in place during the year with the Powys Community Health Council at both County and Local Committee level, and work is under way to transition these relationships into Llais, the new Citizen Voice Body for health and care, so that we can work together on co-productive community engagement to shape the future of health and care.

Given the complex geography of Powys and our dependence on care pathways to multiple acute and tertiary providers outside our borders, we also need to take a bespoke and localised approach to service engagement that works closely with the most relevant stakeholders – for example, focused activity across North Powys as part of our North Powys Wellbeing partnership programme, hyperlocal activity on the Monmouthshire border following an application to close a cross-border branch surgery, and localised activity in mid-west Powys relation to hospital reconfiguration in Hywel Dda.

It is intended to make arrangements to convene the Healthcare Professional's Forum in 2023/2024.

JOINT COMMITTEES

Regular reports on the work of the Joint Committees are provided by the Chief Executive to the Board at each meeting and can be viewed on the Health Board's website.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) & EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC)

The Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee are joint committees of Welsh Health Boards, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35) and 2014 (2014/9 (w.9)) (the WHSSC Directions) and the Emergency Ambulance Services Committees (Wales) Directions 2014 (2014/8 (W.8)) (the EASC Directions).

Update and assurance reports from WHSSC and EASC meetings are reported to the Board; relevant decisions required from WHSSC and EASC that are owned by the Health Board are referred to the Board.

PARTNERSHIP AND COLLECTIVE WORKING

Regular reports on the work of the Partnership Boards are provided by the Chief Executive to the Board at each meeting and can be viewed on the Board and Committee pages of the Health Board website. The Planning, Partnerships and Population Health Committee also has a key role in ensuring that the Health Board is working effectively with partners.

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE (NWSSPC)

An NHS Wales Shared Services Partnership Committee (NWSSPC) has been established under Velindre NHS Trust which is responsible for exercising shared services functions including the management and provision of Shared Services to the NHS in Wales.

More information on the governance and hosting arrangement of these committees can be found in the Health Board's Standing Orders on the Health Board website.

POWYS COUNTY COUNCIL

Powys Teaching Health Board and Powys County Council have a series of overarching Section 33 agreements through which the organisations manage joint arrangements for Care Homes, the Community Equipment Service, Glan Irfon, Information Communication Technology (ICT) services,

Reablement Services and Substance Misuse. In addition to Section 33 agreements, a Memorandum of Understanding is in place regarding services for Carers and there are a number of key areas where there is integrated working, including: Mental Health services, services for people with learning disabilities, older people, and children. Section 33 arrangements are overseen by a Joint Partnership Board which is outlined in the next section.

JOINT PARTNERSHIP BOARD

Powys has been made a region in its own right under Part 9 of the Social Services Wellbeing (Wales) Act 2014. In light of this and combined with the requirements of the Well-being of Future Generations Act (Wales) 2015 and the Social Services Wellbeing (Wales) Act 2014, together with the collective drive towards increased integration between the two organisations, in February 2016, PTHB and Powys County Council established a Joint Partnership Board (JPB). The JPB brings together nominated strategic leaders from both organisations to support effective partnership working across organisations within the county for the benefit of the people of Powys. The Joint Partnership Board is responsible for oversight of the integration agenda. Formal Terms of Reference are in place and a collaborative agreement between the Health Board and Powys County Council has been signed.

In 2022/2023, Powys County Council were responsible for the governance arrangements and administration of the JPB, in 2023/2024 this transfer to the Health Board.

POWYS PUBLIC SERVICE BOARD

The Public Service Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Powys to meet the needs of Powys citizens present and future. The aim of the group is to improve the economic, social, environmental, and cultural well-being of Powys. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan. The Well-being Plan which has been developed through extensive engagement sets out four local objectives for the Powys we want by 2040.

The Health Board contributes to achieving these objectives through the delivery of 'A Healthy Caring Powys' and the Integrated Medium-Term Plan. The PSB has set out its Well-being Plan 12 well-being steps that we will concentrate on to contribute achieving the four local objectives. These steps are those where the biggest difference can be made by developing solutions together.

The PSB reports annually outlining progress and next steps. The PSB annual reports can be found here: Powys Public Service Board – Our Annual Progress Report – Powys County Council

POWYS PUBLIC SERVICE BOARD SCRUTINY COMMITTEE

The PSB Scrutiny Committee was set up in September 2018 as a joint committee with representatives of the organisations which sit on the Powys Public Service Board. This Committee last met in November 2021 and is being reformed with membership limited to elected members of the Local Authority.

POWYS REGIONAL PARTNERSHIP BOARD

The Powys Regional Partnership Board (RPB) was established under the Social Services and Well-being (SSWB) (Wales) Act 2014 in April 2016.

The RPB brings together a range of public service representatives including Powys County Council, the Health Board, third sector, citizens and other key partners, to promote effective working together better to improve health and wellbeing in Powys.

The RPB identifies key areas of improvement for care and support services in Powys. The RPB has also been legally tasked with identifying integration opportunities between social care and health. This has been achieved through building on years of joint working and through the development of 'A Healthy Caring Powys' which has identified key priorities. The key opportunities for integrated working identified and the actions to be taken in support of them are outlined in the Area Plan and focuses on 'Delivering the Vision'. Priorities have been identified as a Focus on Well-being, Tackling the Big 4 (Cancer, Cardio-vascular diseases, respiratory diseases and mental health), Early Help and Support and Joined up Care. The Regional Partnership Board is currently overseeing a major integrated project in North Powys providing a new model of care jointly for health and social care and extending to include supported accommodation and primary education.

Putting people and what matters to them at the centre of health and care services is core to the RPB. The RPB oversees the delivery of this in Powys, which is done through its programmes: Start Well, Live Well, Age Well as well as some other work which cuts across all of these.

The Board's priorities are set out in the Powys Area Plan – 'A Healthy Caring Powys' . Some of the Board's responsibilities include making sure resources are available, that people remain independent for as long as possible, and that health and care services are fully joined up.

To help make this happen, the RPB also has responsibility for allocating funds from Welsh Government's Regional Integration Fund (RIF), which it uses to support key priorities.

MID WALES JOINT COMMITTEE FOR HEALTH AND CARE

Following the Welsh Government's formal recognition of mid Wales as a designated planning area, the Mid Wales Healthcare Collaborative transitioned to the Mid Wales Joint Committee for Health and Care in March 2018. The Welsh Government's long-term plan for the future of health and social care in Wales, 'A Healthier Wales: Our Plan for Health and Social Care', sets out the long-term future vision of a 'whole system approach to a health and social care' which focuses on health, wellbeing and prevention of illness.

The Mid Wales Joint Committee supports this direction of travel, and its Strategic Intent sets out what we will do to ensure there is a joined-up approach to the planning and delivery of regional solutions across organisational boundaries.

The Board receives reports from the Mid Wales Joint Committee as part of the partnership assurance arrangements.

Further detail on the Mid Wales Joint Committee can be found here.

THE CORPORATE GOVERNANCE CODE

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017).

The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies.

The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include self-assessment, internal and external Audit and independent reviews.

The Board complies with the relevant principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

It has been reported in previous Annual Governance Statements, the system of internal control operating across Powys Teaching Health Board is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of policies, aims and objectives of the Health Board, to evaluate the likelihood of those risks being realised and to manage them efficiently, effectively, and economically. I can confirm the system of internal control has been in place at the Health Board for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

The Board is accountable for maintaining a sound system of internal control which supports the achievement of the organisation's objectives. The system of internal control is based on a framework of regular management information, administrative procedures including the segregation of duties and a system of delegation and accountability. It has been supported in this role by the work of the committees, each of which provides regular reports to the Board, underpinned by a sub-committee structure, as shown in Figure 1 of this statement (p22). Some elements of the system of internal control were, however, adapted or suspended during 2022/2023 with the approval of the Board to support the Health Board's response to system pressures, specifically:

- the Risk and Assurance Group met once during the year, although risk management remained the responsibility of managers as set out within the Risk Management Framework and enhanced COVID-19 risk management arrangements were put in place; and
- the escalated leadership arrangements established in 2020/2021 to lead the planning and response to COVID-19 was redeployed from December 2022 to March 2023 to respond to system resilience pressures during the winter period.

CAPACITY TO HANDLE RISK AND KEY ASPECTS OF THE CONTROL FRAMEWORK

The Board collectively has responsibility and accountability for the setting of the organisation's objectives, defining strategies to achieve those objectives, and establishing governance structures and processes to best manage the risks in accomplishing those objectives.

As Accountable Officer I have overall responsibility for risk management and report to the Board on the effectiveness of risk management across

the Health Board. My advice to the Board has been informed by executive officers and feedback received from the Board's Committees, in particular the Audit, Risk and Assurance Committee and Patient Experience, Quality and Safety Committee.

The Executive Committee (Committee of the Board, as per page 25) meetings present an opportunity for executive directors to consider, evaluate and address risk, and actively report to the Board and its committees on the organisation's risk profile.

The Health Board's lead for risk is the Director of Corporate Governance and Board Secretary, who is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Risks are assigned to Directors to lead the organisational response.

Emergency plans and business continuity arrangements have been in place for the duration of 2022/2023, in accordance with the Health Board's statutory duties under the Civil Contingencies Act 2004 and Emergency Planning Guidance as issued by Welsh Government. The organisation continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response to system pressures, and recovery and renewal phases following the COVID-19 pandemic. It has been necessary to ensure that this is underpinned by robust risk management arrangements and the ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve its strategic objectives.

THE RISK MANAGEMENT FRAMEWORK

Robust risk management is a key tool for the Board and is essential to good management. The aim is to ensure it is integral to the Health Board's culture and is an increasingly important element of the Health Board's planning, budget setting and performance processes.

The Board's Risk Management Framework sets out the Health Board's processes and mechanisms for the identification, assessment, and escalation of risks. It has been developed to create 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 best practice risk management are consistent across the Health Board and are fit-for-purpose;
- ensure that risks are identified and managed through a robust organisational Assurance Framework and accompanying Corporate and Directorate Risk Registers;

- embed risk management and established local risk reporting procedures to ensure an effective integrated management process across the Health Board's activities;
- ensure that strategic and operational decisions are informed by an understanding of the organisation's risks and their likely impact;
- ensure that risks to 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
- keep the Board and its Committees suitably informed of significant risks facing the Health Board and associated plans to treat the risk.

The Risk Management Framework sets out a multi-layered reporting process, which comprises the Board Assurance Framework and Corporate Risk Register, Directorate Risk Registers, Local Risk Registers and Project Risk Registers. It has been developed to help build and sustain an organisational culture that encourages appropriate risk taking, effective performance management and organisational learning in order to continuously improve the quality of the services provided and commissioned.

The Risk Management Framework sets out the ways in which risks will be identified and assessed. It is underpinned by a number of policies that relate to risk assessment including incident reporting, information governance, training, health and safety, violence and aggression, complaints, infection control, whistleblowing, human resources, consent, manual handling, and security. The Risk Management Toolkit was developed to assist risk owners in the day-to-day identification, assessment, and management of risk. This is supported with training, support and advice from the Health Board's Corporate Governance Team who endeavor to facilitate a risk aware culture by effectively engaging with services to embed the risk management framework and process.

The Risk Management Framework is available on the Health Board's website here.

MANAGEMENT OF RISKS DURING 2022/2023

Strategic Risks

Strategic risks are those risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence.

Strategic risks are recorded in the Board's Corporate Risk Register (CRR), which provides an organisational-wide summary of significant risks facing the Board. The criteria for a risk to be included in the Corporate Risk register

is:

- 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; and/or
- 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.).

A fundamental review of the Corporate Risk Register was undertaken in 2022/2023 following approval of the 2022-2025 Integrated Medium-Term Plan, in order to ensure that the register reflected consistently the risks to delivering the Health Board's strategic objectives. Key themes arising from the review included:

- financial sustainability and use of resources;
- sustainability of services throughout the health and care system;
- the ongoing need to monitor quality, defined as safety, effectiveness and experience and the potential for harm to patients;
- the risk represented by ongoing challenges in recruiting and retaining staff;
- the focus that continues to be needed on effective working with partners;
- the potential for care to be compromised due to the Health Board's estate not being fit for purpose;
- the ever-present risk of a cyber-attack; and
- the risk presented by a significant public health event/emergency.

EMBEDDING EFFECTIVE RISK MANAGEMENT

Embedding effective risk management remains a key priority for the Board as it is integral to enabling the delivery of our objectives, both strategic and operational, and most importantly to the delivery of safe, high-quality services.

In March 2020, Internal Audit undertook a review of Risk Management and Board Assurance arrangements, which focused on how the Board Assurance Framework and Risk Management Framework are being implemented and updated in-line with the revised IMTP. A limited assurance rating was provided to the Board in respect of this review.

In July 2022 a further review was undertaken which recognised the progress made in the area and provided a reasonable assurance rating. Highlighted in the review was the Risk Management Framework (RMF) and Toolkit, approved by the Board in November 2021 which together provide a comprehensive and user-friendly approach to organisational risk management strategy. The Framework outlines the roles and

responsibilities for risk management, the organisational risk management structure, Corporate and Directorate monitoring and reporting lines, the Board's approach to risk appetite and risk management processes including the escalation, consolidation and aggregation of risks. The Framework and Toolkit (alongside the Risk Appetite Statement) are reviewed on an annual basis by the Board. This was undertaken in Quarter 3 of 2022/2023 and a revised version was approved by the Board in November 2022 with no material changes made.

As a result of the pandemic the review of the Board Assurance Framework (BAF) was paused in 2020/2021. In the first quarter of 2023/2024 work will begin to refresh the Assurance Framework Principles and Board's Assurance Framework (BAF) to ensure robust assurance is provided to the Board and Board Committees and inform focus and decision making at Board, Executive and Directorate level.

Further work will also be undertaken in 2023/2024 to strengthen the arrangements in relation to the Risk and Assurance Group to enable coordination of the achievement of the Risk Management Framework's objectives through the organization's directorates, by embedding risk management and establishing local risk reporting procedures. This will enable the effective integrated management of risk and assurance. The Group will also seek 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 (BAF).

RISK APPETITE

The Board's Risk Appetite Statement sets out the Boards strategic approach to risk-taking by defining its risk appetite thresholds. It is a 'live' document that is regularly revised and modified, so that any changes to the organisation's strategies, 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.

In updating and approving its Risk Appetite Statement, the Board considered the Health Board's capacity and capability to manage 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.

In 2021/2022 the Risk Appetite Statement 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 Health, Caring Powys'. In recognising the risks inherent in healthcare services, the risk appetite statement starts at the basis of a low appetite. The underlying principles of the 2021/2022 Risk Appetite Statement were maintained in 2022/2023.

All Board Members were involved in preparing the statement and the complexities in relation to the establishment of the Board's appetite in respect of quality in the context of current and future system pressures and financial outlook was recognised. The Risk Appetite Statement for 2022/2023 sought therefore to further consider the nature of the external environment within which the Health Board operates and the need for greater clarity and granularity to aid decision making and the treatment of risk.

The following risk appetite levels, have been included and have been used as the basis in determining the appetite levels set out in the Statement:

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.
Minimal	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.
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 thresholds provided with the Risk Appetite Statement are provided below:

Risk Category	Description
APPETITE FOR RISK: Averse	
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: Minimal	
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.
APPETITE FOR RISK: Cautious	
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

Risk Category	Description
	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.
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

Risk Category	Description
	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 the third sector, 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.
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 centered 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.

THE HEALTH BOARD'S RISK PROFILE

As can be seen from the Heat Map at Figure 7, at the end of March 2023 a number of key risks to the delivery of the Health Board's strategic objectives had been identified. Full details of the controls in place and actions taken to address these risks can be found in the Corporate Risk Register on the Health Board's website here.

Figure 7: Strategic Risk Heat Map

In-Committee Risks (Private)			-A cyber-attack results in significant disruption to services and quality of patient care				
Impact	**Catastrophic**	**5**				- the Health Board fails to manage its financial resources in line with statutory requirements -the urgent and emergency health and social care system fails to deliver a timely response for care for Powys citizens	
	Major	**4**			- a significant public health event/emergency impacts on provision, continuity and sustainability of services	-the Health Board fails to adequately allocate resources, including transformation capacity, to improve health outcomes/experience and reduce inequalities -citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers -failure to plan for, recruit and retain an appropriate workforce results in an inability to sustain high quality services -the care provided in some areas is compromised due to the Health Board's estate being not fit for purpose	-inequity of access to planned, secondary and specialised care results in poorer outcomes and experience for some Powys citizens -the demand and capacity pressures in the primary care system lead to services becoming unsustainable
	Moderate	**3**			-ineffective partnership working, including on service change/reconfiguration, results in poorer outcomes and experience for citizens of Powys		
	Minor	**2**					
	Negligible	**1**					
		1	**2**	**3**	**4**	**5**	
		Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**	
		Likelihood					

An overview of the key risks (i.e., those in the red section of the Heat Map) and actions taken to manage the risks are provided in Figure 8.

Figure 8: Key Risks and Controls

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 001 – Risk Score 20] the Health Board fails to manage its financial resources in line with statutory requirements	**CONTROLS IN PLACE / ACTION TAKEN:** ▪ Balanced Financial Plan included in IMTP Submission. ▪ Financial Control Procedures and Standing Orders and Standing Financial Instructions and Budgetary Control Framework, Budgetary Control Audit rated as substantial assurance. ▪ Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks ▪ Service Reviews / Performance reviews to strengthen financial monitoring of performance and longer-term impact on financial plan (support better decision making). ▪ Contracting Framework to monitor and forecast the impact of arrangements in 2022/2023 and going forward ▪ Task and Finish Groups established for CHC, Variable Pay and Contracting with identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. ▪ Savings Plan monitoring and reporting linked to the Efficiency Framework and Investment Benefits Group and supporting the VBHC approach. ▪ Regular communication and reporting to Welsh Government and Finance Delivery Unit regarding the impact of pressures and ongoing Covid-19 and expectations regarding funding and impact on Financial Plan and underlying position. Additional control - Finance and Performance Group established as sub-group of Executive Committee. Initial focus on savings and opportunities. **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Strengthening of the capability and sustainability of the Finance Team and establish a modernisation programme to improve function performance and delivery. ▪ Financial Plan for 2023/2024 being developed, including robust assessment of cost pressures and establishment of saving schemes. ▪ Increase focus on longer term efficiency and sustainability (value) and balance within year delivery as needed for plan. New Efficiency Framework approved and live and Value Based Healthcare Board established.

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 004 – Risk Score 20] the urgent and emergency health and social care system fails to deliver a timely response for care for Powys citizens	**CONTROLS IN PLACE / ACTION TAKEN:** ▪ Daily management system in place to manage patient flow including multiple daily local and national calls. ▪ Continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos. ▪ Regular reviews of long stay patients in community hospitals to reduce average length of stay. ▪ Training on discharge and complex care management is provided to ward based staff through the Complex Care and Unscheduled Care Team. ▪ Review of urgent care team arrangements, with exploration of a business case to advance capacity of Discharge Liaison officers. ▪ Care coordination in place across all acute hospital sites to facilitate timely repatriation of patients back into Powys. ▪ Bed escalation plans activated to support the national programme of extra community care beds across Wales by end of October 2022 (within limits of staffing availability). ▪ Care Home risk and escalation plans to support care home capacity. ▪ Social care fragility and delays – regular attendance at Head of Service level to Delivery Coordination Group and escalated discussions at Director and CEO level. ▪ Delivery Coordination Group in place to manage operational delivery across whole system. ▪ Winter Plan developed to manage whole system pressures. Urgent review of escalation options in development between health and social care to increase community care capacity and to reduce delays. ▪ Industrial action command and control structure in place to manage service impact and to minimise disruption to services. **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Daily operational management of patient flow ▪ System escalation including senior officer daily review and weekly Gold level oversight. ▪ Review of Complex Care arrangements in place to improve system improvements and to reduce delays. ▪ Transformational development of urgent care system (6 Goals) including community care capacity and focus on handover delays ▪ Urgent escalation plan in development to secure additional system impact to improve community care capacity and flow. ▪ Industrial action management plans in place, coordinated and reporting at bronze, silver and gold levels.

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 005 – Risk Score 20] inequity of access to planned, secondary and specialised care results in poorer outcomes and experience for some Powys citizens	**CONTROLS IN PLACE / ACTION TAKEN:** ▪ Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand both yearend position 2022/2023 and for 2023/2024 (latter with reference to NHS Wales Planning Framework 2023-26 access target requirements by June 2023; and NHSE access target requirements by March 2024). ▪ Medinet contract extended – proposals being developed to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. ▪ Identify key priorities to deliver elective treatments within ministerial access targets. ▪ Implementation of Integrated Performance Framework. ▪ Ongoing scrutiny and oversight through CQPR meetings utilising Commissioning Assurance Framework with escalation through monthly ICAM meetings and through Integrated Performance Report. ▪ Provider issue summary and fragile services log. ▪ Develop funding proposal to WG to support recovery of waiting times for Powys activity in English Providers. Ensure Powys residents are included in the activity being sourced through the West Midlands Mutual Aid hub. **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Secure performance improvement trajectories from providers. ▪ Insourcing and outsourcing options being considered (subject to capacity). All providers now expected to agree improvement trajectories in light of 2022/2023 guidance published for planned care recovery.

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 008 – Risk Score 20] the demand and capacity pressures in the primary care system lead to services becoming unsustainable	**CONTROLS IN PLACE / ACTION TAKEN:** ▪ Close monitoring and liaison with practices to offer support including regular review of the sustainability matrix to monitor changes and sustainability funding application process. ▪ Implementation of Accelerated Cluster Development Programme. ▪ Health Board management of practices if contracts are handed back until tendering process is successful. ▪ Adastra – Continued daily participation in national BCI calls with 111 to manage situation. Following successfully testing Shropdoc Adastra was reinstated on 19/10/22 albeit with limited functionality. System being used for the patient contact/record. Manual admin process still required at the front end. Reactivation of GP OOH report messaging and special patient notes now in place. Fully operational Adastra and CAS system hoped to be in place before the 4 day Christmas BH period. 111 and Shropdoc remain in BCICommissioning of urgent access slots across Powys and new contract in place for Llandrindod. Implementation of the new Dental contract 2022/2023 metrics should increase provision and access. Community Dental Service clinics support urgent access to mitigate against gaps in provision. Mid-Year Review meetings completed and in year contract adjustments being considered. Awaiting national guidance to support year end. **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Primary Care – Ongoing regular review of sustainability matrix and applications for support. Weekly review of Escalation tool ▪ Regular discussions with Cluster Leads to discuss ongoing demands and additional actions to manage peaks ▪ Implementation of the Accelerated Cluster Development Programme to meet national milestones. ▪ Following the Adastra Cyber incident on the 4th August, that as of today a fully functioning Adastra system is now operational across Wales and Shropdoc.

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 006 – Risk Score 16] failure to plan for, recruit and retain an appropriate workforce results in an inability to sustain high quality services.	**CONTROLS IN PLACE / ACTION TAKEN:** ▪ A calendar for a rolling programme of recruitment events has been developed which includes student streamlining, department for working pensions and open days across the county. ▪ All roles on trac are monitored to improve the time to hire. ▪ Services continue to ensure all key vacant posts are being processed in a timely manner. ▪ Rolling adverts for all substantive and bank nurse vacancies remain open across all sites. ▪ Interviews were held in January for the remainder of phase 1 of the international all Wales nurse recruitment programme, 5 nurses were successful. Offers have been issued and accepted with a target in country date of 11th April 2023 (this is subject to changes with visa applications) ▪ Interviews were held in January for the remainder of phase 1 of the international all Wales nurse recruitment programme, 5 nurses were successful. Offers have been issued and accepted with a target in country date of 11th April 2023 (this is subject to changes with visa applications) ▪ Weekly reports on temporary staffing are produced and shared with Head of Nursing. ▪ The Executive Director of Nursing and Midwifery has undertaken a formal review of community ward establishments to ensure there are recommended minimum safe staffing levels that align with the current service delivery model. ▪ Further work has commenced on the development of an Accelerated Sustainable Model. ▪ By the end of Q1 we will have undertaken a wellbeing roadshow at each of the main hospital sites across the county **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Working with partners a joint recruitment event across Health and Social Care is being explored. ▪ Develop a proposition for the candidate journey from application to induction, identifying changes or omissions within the current process that are required to improve the candidate journey. ▪ Roll out the organisationally agreed workforce planning model by delivering training which supports services to develop their resource plans. ▪ Undertaken a wellbeing roadshow at each of the main hospital sites across the county

RISK DESCRIPTION	CONTROLS IN PLACE, ACTION TAKEN & IMPROVEMENT ACTIONS
[CRR 010 – Risk Score 16] the care provided in some areas is compromised due to the Health Board's estate being not fit for purpose	**CONTROLS IN PLACE / ACTION TAKEN:** **ESTATES** ▪ Specialist sub-groups for each compliance discipline ▪ Risk-based improvement plans introduced ▪ Specialist leads identified ▪ Estates Compliance Group and Capital Control Group established ▪ Medical Gases Group; Fire Safety Group; Water Safety Group; Health & Safety Group in place. New Ventilation Safety Group set up. ▪ Capital Programme developed for compliance and approved ▪ Capital and Estates set as a specific Organisational Priority in the Health Board's Annual Plan ▪ Address (on an ongoing basis) maintenance and compliance issues ▪ Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards **CAPITAL** ▪ Capital Procedures for project activity ▪ Routine oversight / meetings with NWSSP Procurement ▪ Specialist advice and support from NWSSP Specialist Estates Services ▪ Audit reviews by NWSSP Audit and Assurance ▪ Close liaison with Welsh Government, Capital Function ▪ Reporting routinely to P&R Committee ▪ Capital Programme developed and approved ▪ Detailed Strategic, Outline and Full Business Cases defining risk ▪ Capital and Estates set as a specific Organisational Priority **ENVIRONMENT** ▪ ISO 14001 routine external audit to retain accreditation ▪ Environment & Sustainability Group ▪ NWSSP Specialist Estates Services (Environment) support and oversight ▪ Welsh Government support and advice to identify and fund decarbonisation project initiatives **IMPROVEMENT ACTIONS TO BE TAKEN FORWARD IN 2023/2024:** ▪ Implement the Capital Programme and develop the long-term capital programme. ▪ Continue to seek WG Capital pipeline programme funding continuity: seek alternative capital funding opportunities to mitigate funding reduction for 2022/2023 and develop projects in readiness for any capital slippage in latter part of financial year cycle. Additional funding from Welsh Government being provided for 2022/2023 (i.e., year-end slippage). Monies will be spent across equipment, ICT and estate. Formal notification also imminent for final allocation Estates Funding Advisory Board (EFAB) for 2023/2024 onward. ▪ Develop capacity and efficiency of the Estates and Capital function. ▪ Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to

	address limited establishment staff numbers in Works Team and recruitment challenges. Initial resource review undertaken by IEG in June 2022 with financial constraints necessitating more detailed analysis. This has been further discussed in IEG in October and a more detailed paper will be brought to IEG in December including demand levels and performance around Planned and Preventative Maintenance (PPMs) this will be further discussed at IEG in March 2023

The Board received and reviewed the Corporate Risk register at each meeting of the Board during 2022/2023. As a result of the reviews undertaken by the Executive Committee and the Board, the risk scores for a number of risks changed during the year in the context of the external environment, and other developments such as improvements made to the control process.

As undertaken in 2022/2023, following Board approval of the Integrated Medium-Term Plan for 2023-2026 a full review of the Corporate Risk Register will take place to ensure priorities are identified, assessed and mitigating actions established, as well as assurance levels assessed.

EMERGENCY PREPAREDNESS

The Civil Contingencies Act 2004 and Emergency Planning Guidance issued by Welsh Government, places statutory duties on the Health Board to ensure arrangements are in place to respond to emergencies and major incidents. To meet this duty, the Health Board has a range of emergency response and business continuity plans in place to respond to emergencies and disruption to services. This includes the provision of training and participation in other emergency preparedness events.

Over the last twelve-month period, the Health Board has used the arrangements outlined in our plans to respond to a wide range of business continuity events that have impacted on the Health Board's services.

In addition, the Health Board continues to regularly engage and work collaboratively with our multi-agency partners on a wide range of preparedness activities and also in response to incidents. This collaboration is achieved through the Dyfed Powys multi-agency Local Resilience Forum and with other NHS Wales organisations through a variety of groups.

To demonstrate compliance with the Civil Contingencies Act, the Health Board is required to submit an assessment on the Health Board's emergency preparedness activities to Welsh Government on an annual basis, and also produces an Annual Report on Civil Contingencies Planning for the Board.

PLANNING ARRANGEMENTS

The organisation's planning arrangements in 2022/2023 form a key part of the Performance Report section of the Annual Report. Further detail can be found throughout the Performance Report.

KEY ASPECTS OF THE CONTROL FRAMEWORK

In addition to the Board and Committee arrangements described earlier in this document, I have worked to further strengthen the Health Board's control framework over the last 12 months. Key elements of this include:

QUALITY GOVERNANCE ARRANGEMENTS, INCLUDING CLINICAL RISKS AND CLINICAL AUDIT PLAN

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- A Healthier Wales
- Core Commissioning Requirements.

With our aims to continuously improve and learn, new legislative requirements support the quality governance framework during 2022/2023. The Health and Social Care (Quality and Engagement) (Wales) Act 2020, places more responsibility on health and care organisations in Wales. Enhancing quality, honesty and transparency, the legislation provides the Health Board with a Duty of Quality, Duty of Candour, and establishes a Citizen Voice, enriching engagement with our patients, relatives, carers, staff, and communities. Developing our organisational culture and embedding the Duty of Candour are critical in being open and honest with our patients and service users where our services have not met expectations or caused harm. Candour will be utilised to drive improvement whilst embracing improvement and innovation opportunities. The Health Board will deliver the Duty of Quality by ensuring services provide the highest quality of care for our patients, relatives, carers, staff and communities. We are committed to improve the experience of care and seek opportunities to provide positive patient experiences through the patient journey across services. Our vision is quality-driven, with data driven improvement and learning through experience.

The existing quality governance structure has been maintained. The Patient Experience, Quality and Safety Committee continued to receive reports on

assurance and escalated risks linked to patient experience, quality, and safety.

The key aspects of the quality governance arrangements in the Health Board are:

- Commissioning Assurance Framework:
    - Quality
        - Safety
        - Effectiveness
        - Experience
    - Access
    - Cost/Finance
    - Governance & strategic change
- Putting Things Right (Concerns, Incident and Claims)
- Clinical Audit
- Data – CHKS – healthcare intelligence and quality improvement, benchmarking
- External Reviews – e.g., Getting It Right First Time
- Professional practice supervision/regulation
- Staff Surveys
- Organisational Development Framework
- Relationships/Escalations – Care Quality Commission, Healthcare Inspectorate Wales etc

A focus on quality has been maintained through the following activity in 2022/2023:

- Recommendations from the Audit Wales Review of Quality Governance (Oct 2021). The Review was positive overall with helpful areas for improvement identified.
- Quality governance arrangements within service groups continue to embed, with focus on improving quality metric reporting which will be supported by the implementation of the Integrated Performance Framework (IPF).
- Implementation of the Medical Examiner Service.
- National Nosocomial COVID-19 Programme (NNCP) implementation.
- Safeguarding & public protection annual report presentation to the Patient Experience, Quality and Safety in December 2022.
- Specific maternity and neonatal governance arrangements in place including our Maternity Assurance Framework.

There has been continued focus on the health board's formal process, in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 also known as Putting Things Right, which aims to address concerns in a proactive, timely and open manner.

Organisational learning from concerns has continued to develop, taking account of the need to learn quickly and effectively during the pandemic period, and ensuring the Health Board listen and learn from patient and staff experiences.

The Learning from Experience Group has created the opportunity to discuss and triangulate quality issues and supports the organisation in expanding learning across all services. The implementation of the CIVICA patient experience system during Q3 will be realised in 2023/2024. The Health Board wide approach to ensure patient experience is triangulated with a strong focus on the provision of person centred, outcome focused care to help inform decision making in relation to service planning design, delivery, and evaluation.

Health and Care Standards

The extant Health and Care Standards continue to inform the quality of services provided in in-patient settings. The Health and Care Standards are cross referenced as part of Committee reporting, with associated risks and escalation raised. Peer review quality checks across services reflect the Health and Care Standards, albeit a reduced programme during the last year, inform improvement and development in care and treatment supported with refreshed policies and procedures.

Commissioning Developments and Assurance Frameworks

The organisation's Commissioning Developments and Assurance Framework in 2022/2023 forms a key part of the Performance Report section of the Annual Report. Further detail can be found throughout the Performance Report.

Clinical Audit

During 2022 the clinical audit plan has been further developed to bring greater focus on ensuring that learning from events has been embedded into practice. Areas of focus include:

- Themes or significant concerns identified during investigations of Nationally Reportable Incidents or complaints.
- new policies or changes to existing policy / practice to confirm new practice is established.

- the prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- clinical audits required to confirm that practice has improved where concern had been raised.

There has been improved triangulation of learning through the learning from experience group.

Service Group arrangements

The Community Services Group refreshed its approach to the management of clinical audit. A service-level quality meeting is synchronised to the timetable of the Patient Experience, Quality and Safety Committee. This will allow for the efficient flow of audit reports.

For Therapies, clinical audit is an agenda item for each monthly Heads of Service Meeting.

For the Mental Health Team, learning from clinical audit is presented to the Mental Health learning group and Operational Managers group as agenda items. Recommendations are put into action through these groups.

The Health Board continued to participate in National Audits. Findings were shared via the learning group.

The local clinical audit list remains large. Quality dashboards are being developed which will be updated by teams. Live information will be visible to them to facilitate more agile learning. They will ultimately replace some of the clinical audits.

An update report detailing progress against the 2022/2023 local clinical audit plan, describing findings from the audit was reported to, and approved by, the March and the October 2022 meetings of the Patient Experience, Quality and Safety Committee. The audit plan for 2023/2024 was approved by the February Patient Experience, Quality and Safety Committee.

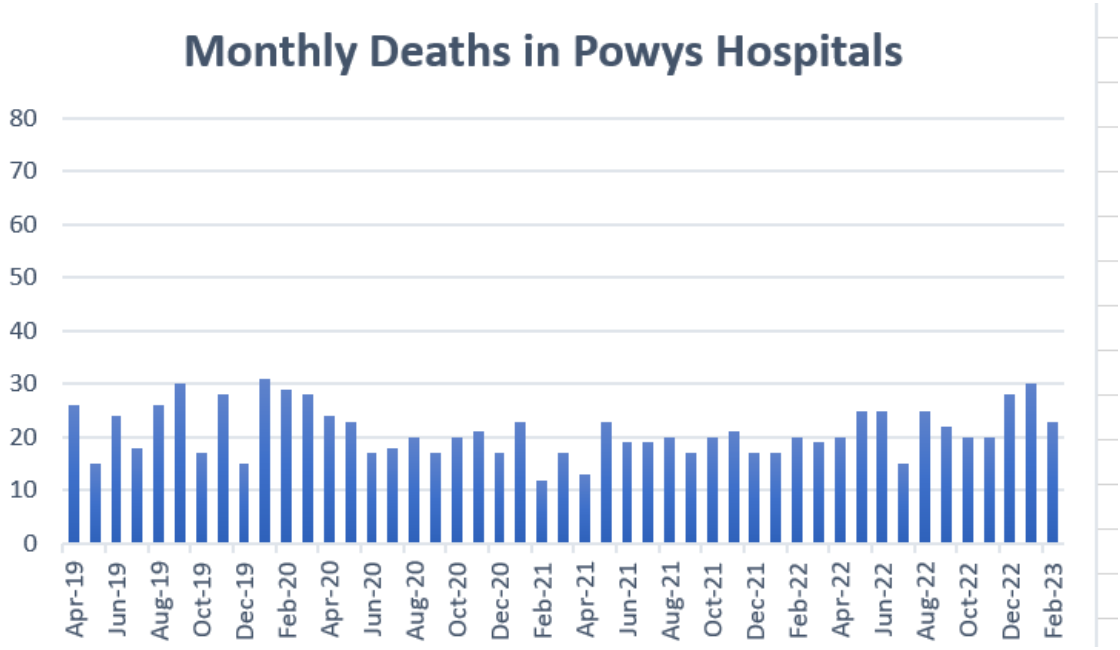
Complaints and Concerns Framework

A continued focus on compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 has been maintained. This is extended to the way in which serious incidents are managed, through to investigation, learning and sharing of lessons. Investment in training during 2022/2023 has built on existing knowledge and experience across the Health Board.

These and further information on Putting Things Right can be found on the Health Board website.

Mortality Reviews

During the COVID-19 pandemic, the number of monthly deaths in Powys Community Hospitals has remained comparable with the period before the pandemic. The average number of monthly deaths increased slightly from 22 per month in calendar year 2019 to 23 per month in calendar year 2020, before falling to 18 per month, and 21 per month in 2021 and 2022 respectively.



A mortality report was submitted to the November 2022 meeting of the Patient Experience, Quality and Safety Committee, which detailed the findings of the previous round of reviews. No major clinical concerns were identified, and feedback given to the medical staff encouraging the use of Treatment Escalation Plans had dramatically improved the adoption of this process.

As part of part 2 mortality review discussion, themes were identified, including timing and documentation of treatment decisions. There was positive learning around visibility of Multi-Disciplinary Team notes and decision making on some sites. It was agreed that this would be fed through the learning group and work would be undertaken with the ward managers to encourage earlier discussion and more standardised documentation to improve visibility.

During 2022, South Powys hospitals began to submit cases to the Medical Examiner service. A total of 13 cases have been referred back to the Health

Board by the Medical Examiner Service. Seven cases were issues raised by family members concerning care provided by groups other than the Health Board, such as out of county DGHs, Welsh Ambulance or private carers. Six cases were requests from the Medical Examiner to review care where the examiner felt that whilst there was no obvious significant failing in care, the organisation might identify minor areas for improvement. Of these cases, none have been found to have significant concerns in care.

The medical examiner role is now rolling out across the remaining community hospitals. Formal Health Board Mortality reviews will cease but ward-based team Morbidity and Mortality meetings will continue. Learning from the Medical Examiner feedback will be considered by the Quality and Safety team and themes fed through the learning group.

The final round of Health Board mortality reviews will include all of the cases prior to Medical Examiner roll out. There has been delay due to operational pressures but is in progress.

Learning from Experience Group

The Learning from Experience Group, comprising all Clinical Executive Directors, the Head of Medicine Management and invited Assistant Directors met in May, June, August, and December of 2022.

The group provides an opportunity for senior staff to informally discuss issues around quality and learning and use this discussion to guide the activity of other groups within the organisation. During 2022, the subjects of; Incident investigation, staff use of the Datix system, mortality reviews and the Medical Examiner Service, clinical audit, coroner's cases, and organisational risk management were all discussed.

Themes from concerns and incidents, Medical Examiner feedback, the cancer harm review process are considered by the group. Agreement is made on mechanisms for cascading learning and suggestions are made around future clinical audits based on the themes discussed.

Actions agreed by the group included the organisation of a Development Day to discuss the Quality and Engagement Act and the organisation's response to the Welsh Risk Pool review of consent to treatment arrangements in Powys. The Terms of Reference for the Group are being refreshed to ensure alignment to the Quality and Engagement Act.

EXECUTIVES PORTFOLIOS

In May 2022, the Board approved an updated Scheme of Delegation and Reservation of Powers. This document set out the delegation of responsibility to Executive Directors. The allocation of responsibilities is

based on ensuring an appropriate alignment of accountabilities and authority within each Executive Directorate and Executive Director portfolio, and to also ensure that Executive Directorates focus on their core responsibility. A small change was made in January 2023 with the addition of a second non-Executive (non-voting) Director, (Corporate Governance). An overview of Executive Director portfolios is set out in ***Figure 9.***

Figure 9: Executive Portfolios – April 2022 – March 2023

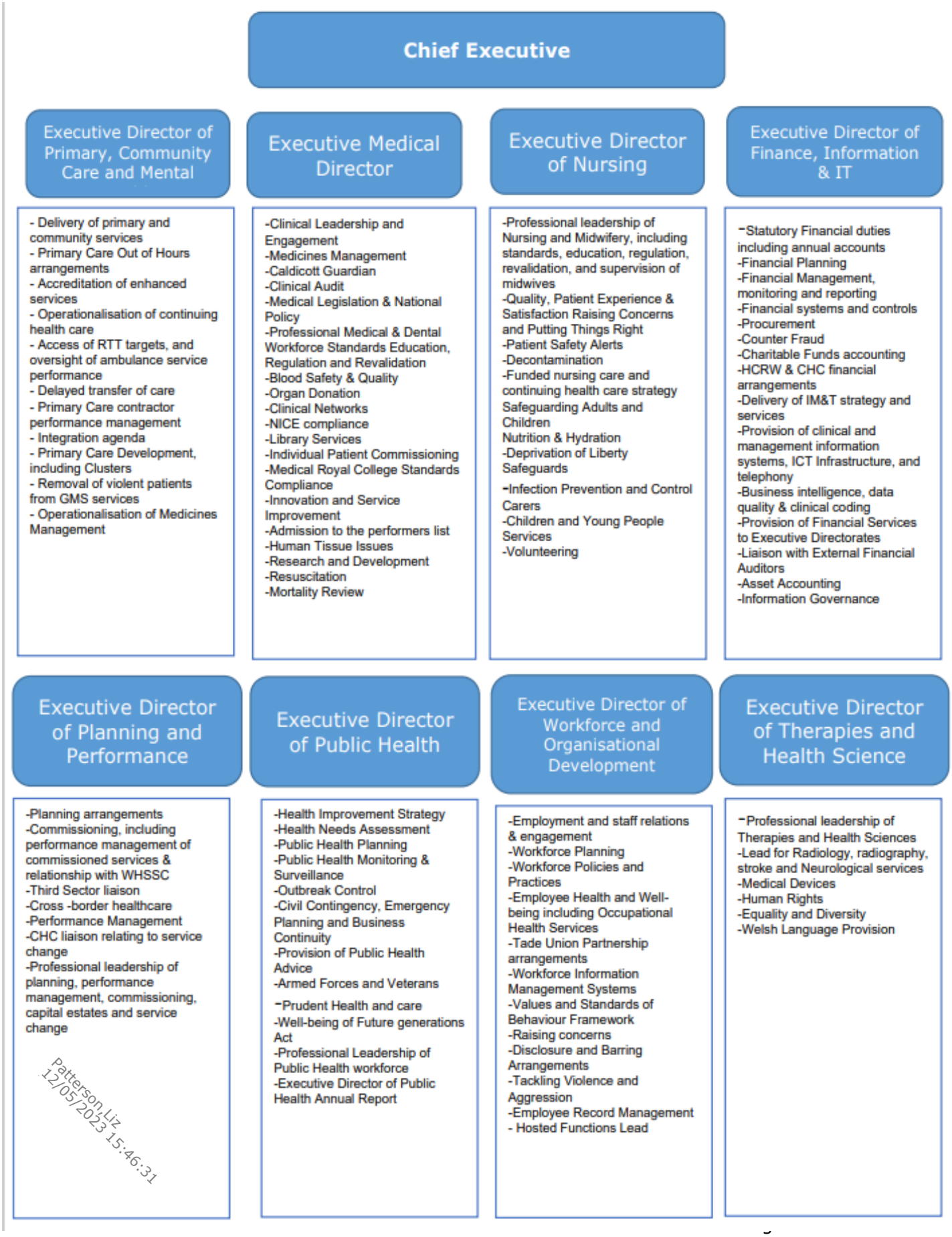
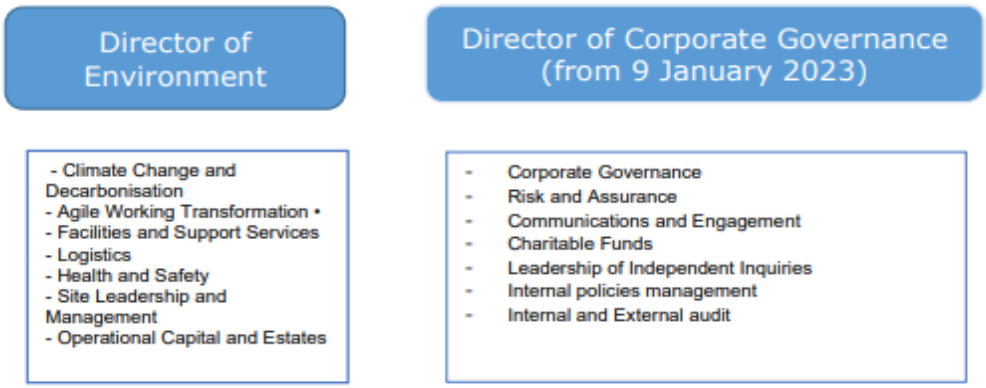


Figure 9 continued Non-Executive (non-voting) Director Portfolios



Staff and Staff Engagement

The Local Partnership Forum is a formal advisory group providing opportunity for two-way discussion and collaboration between the health board management and staff. ensuring action is considered and taken in response to feedback. Engagement with staff side has been key to ensuring collaboration on range of staffing and well-being initiatives.

A summary of activity include:

- Wellbeing Framework and plan and Organisational Development Framework.
- Workforce Futures Engagement and Wellbeing theme.
- Retainment of the Corporate Health Gold standard award.
- Wellbeing pulse surveys using the 7 engagement index questions from the NHS national survey.
- Development of the SharePoint Staywell Wellbeing pages, which continue to be the primary source of self-help information as well as the advertising portal for events and other opportunities. Including the introduction of Financial Wellbeing pages.
- Wellbeing Roadshows – A series of well attended staff roadshows have taken place across the county, starting in December through to May which enabled staff to speak face to face with a range of support functions such as VIVUP (Employee Assistance Programme/ Counselling service) , Freedom Leisure, Health Shield, Chat2Change, Trade Unions, Menopause.
- A suite of Positive Psychology and Resilience workshops with topics such as: Joy at work – Positive Psychology and the Science of Happiness, Emotions at Work – how we perceive, use, understand

and manage emotions at work, Trust and Psychological Safety – creating an environment where everyone can flourish.

Communication and Engagement

During 2022/2023 the Health Board's engagement and communication team has supported the wider Health Board activities as we move from pandemic to endemic including active support for the COVID-19 spring and autumn booster campaigns.

Given the continued ease of restrictions, engagement and consultation activity has continued to resume and has included:

- Engagement on proposals affecting stroke services in Herefordshire and Worcestershire.
- Assessment of options for the future delivery of nuclear medicine services in BCUHB.
- Engagement on the future shape of Cochlear Implant and BCHI services in South Wales.
- Engagement following an application from Crickhowell Group Practice to close their branch surgery in Gilwern.
- Consultation on the location for a new urgent and planned care hospital site in Hywel Dda (with consequential impact for communities in the Llanwrtyd Wells area who currently access acute hospital services in Carmarthen).
- Informal engagement and planning ready of the launch shortly after year end of a period of formal engagement by the Emergency Ambulance Services Committee on the future service model for the NHS Emergency Medical Retrieval and Transfer Services (EMRTS) in partnership with the Wales Air Ambulance Charity.
- Support for the PSB and RPB-led engagement on the draft Well-being plan and Area Plan, followed by statutory consultation on the Well-being Plan for Powys.

Informal stakeholder engagement activity has been ongoing for a number of other projects and programmes, including the redevelopment of Bro Ddyfi Community Hospital and the development of Knighton Hospital as an interim re-ablement facility to provide more care closer to home whilst the ward remains closed due to ongoing staffing and recruitment issues.

Engagement work also commenced for the North Powys Wellbeing Programme Outline Business Case, with an expanded programme of events including a Newtown community festival in September 2022. This event fell during the period of official mourning following the death of Her Majesty

Queen Elizabeth II so was sensitively refocused to ensure an engaging event for children and the wider community.

A wider programme of communication activity has been able to recommence as the requirements of the COVID-19 pandemic response reduced, but critical activities remained to retain awareness of protective behaviours and continued risk.

Key areas of focus included our winter resilience communications plan. This involved regular engagement with key stakeholders including the Community Health Council, County Council, MSs and MPs, staff, public briefing sessions, PAVO and wider partners to help inform the Health Board's plans and to support and encourage everyone to play a part in Keeping Powys Safe. This has included a focus on Help Us Help You and promotion of NHS 111 Wales services. Given the increasingly challenging financial context the messaging was also linked with Cost-of-Living advice including a new cost of living hub on the Health Board website.

With industrial action taking place during the year, the team was also central to the Health Board response, providing public messaging to help people access the right service at the right time – with the added complexity of different action affecting Powys, neighbouring Health Boards, and services in England in different ways at different times.

Key campaigns have included SilverCloud Online CBT, and the launch of a new ChatHealth service to help schoolchildren access advice from their school nursing team.

The new SharePoint intranet site went live in April 2022 and has expanded considerably during the year, joined by new internal communications platforms including Viva Engage (formerly Yammer). In support of wider staff engagement, the team has supported the re-establishment of a programme of staff health and wellbeing roadshows. Whilst a Diolch Powys staff engagement event was paused in September 2022 during the period of official mourning, Q4 saw planning under way for the NHS 75th birthday and the relaunch of the Staff Excellence Awards which will take place in 2023/2024.

On the national stage, Health Board staff have led the national programme of communication and promotional work to enable the launch of the new statutory duties of candour and quality which came into force from 1 April 2023. This has included working with partners across the NHS and beyond to develop and deliver a comprehensive suite of resources to help organisations implement the new statutory duties.

Other key priorities for 2023/2024 include engagement and communication in support of the accelerated service model, and continued re-

establishment of continuous engagement mechanisms aligned to the establishment of the new Llais Citizen Voice Body.

Information Governance

Information Governance (IG) is the way in which the Health Board handles all information, in particular, personal, and sensitive information relating to our patients, services users and employees. IG sets out the requirements and standards that the Health Board must achieve to ensure it fulfils its obligations to handle information securely, efficiently, and effectively.

Reliance on IG continue to increase as the Health Board's services have continued to introduce new technologies to enable them to share information and communicate with patients and staff. Some of these changes have taken place on a national level and IG Managers across Wales have been involved in ensuring the necessary assurances were in place to meet legislative requirements.

Responsibility for IG in the Health Board rests with the Executive Director of Finance IT and Information Services and the Head of Information Governance and Records is the Health Board's nominated Data Protection Officer (DPO) in line with the requirements of the UK General Data Protection Regulation (UK GDPR). The Executive Director of Finance, IT and Information Services also acts as the Senior Information Risk Owner (SIRO), the Executive Medical Director is the nominated Caldicott Guardian, and the Chief Clinical Information Officer is fulfilled by the Executive Director of Therapies and Health Sciences.

Compliance with Legal and Regulatory Framework is co-ordinated and monitored by the IG Team. Key legislation such as the UK General Data Protection Regulation, Data Protection Act 2018, Environmental Information Regulations and Freedom of Information Act. Performance against IG-related legislation is captured and reported to our Delivery and Performance Committee.

Information Governance Training

As of 31 March 2023, the Health Board achieved a rate of 89% for the mandatory Information Governance training which is a small decrease from the previous year.

The profile of the Information Governance awareness has been raised further this past year. Through:

- assuring new and existing systems
- collaborating with services to identify and develop information sharing agreements,
- investigating IG related incidents

- providing tailored training sessions.
- issuing IG Alerts
- updating the internal and external webpages
- providing advice as part of digital transformation
- better presence in meetings/groups
- close working relationships with colleagues throughout Wales and across the border through national groups.

Personal Data Related Incidents (Breaches)

A personal data incident is a breach of security leading to the accidental or unlawful destruction, loss, alteration, un-authorised disclosure of, or access to personal data. In line with GDPR requirements, all personal data incidents must be reviewed daily, and any incidents deemed significant must be formally reported to the Information Commissioner's office (ICO) within 72 hours. During 2022/2023, four personal data incidents were formally reported to the ICO. The Health Board did not incur any financial penalties from the ICO because of those incidents reported. The Health Board has adopted any recommendations made and the actions in these areas and progress is tracked (as part of the audit recommendations tracker) until complete. The Health Board continues to take on board any lessons learned, or feedback received. Figures on the number of IG related breaches are reported to our Delivery and Performance Committee.

Freedom of Information Act

The Freedom of Information Act 2000 (FOIA) gives the public right of access to a variety of records and information held by public bodies and provides commitment to greater openness and transparency in the public sector. During the period 1 April 2021 to 31 March 2022 the Health Board received a total of 327 requests for information, with 227 of these answered within the 20-day timeframe. Eight requests for internal review were received and responded to with no further action being taken by the requestor. As a Health Board, we are committed to complying with the FOIA by making information readily available via our Publication Scheme which can be found on the Health Board's website:

UK General Data Protection Regulation (GDPR) and Access to Health Records Act (AHRA) 1990

UK GDPR and AHRA give individuals and family members the right to access their own or someone else's personal data. This is commonly referred to as a Subject Access Request (SAR), and the organisation has a statutory timeframe in which to respond. During the period 1 April 2022 to 31 March 2023, the Health Board responded to 476 SARs, with 437 of those responded to within the statutory timeframe.

Welsh Information Governance (IG) Toolkit

The Health Board is required to undertake the NHS Wales Information Governance Toolkit for Health Boards and Trusts and all NHS Wales organisations must complete this to provide assurance that they are practising good data security and that personal information is handled correctly.

As a result of progress made on the Records Management Improvement plan since February 2022, it is anticipated that the toolkit submission will demonstrate an improvement in our compliance levels.

An information governance workplan is in place which the team will continue deliver during 2023/2024.

Information Security

Strengthening local processes whereby a group of digital experts review and approve the procurement of any local new or existing digital solution to ensure complies with relevant legislation and standards (UK GDPR and NIS Regulations) thus avoiding PTHB being put at un-necessary risk, such as from a Cyber Attack, loss of data, incident/breach of patient's data, fine from the ICO or NCSU.

Information Sharing: National WASPI Code of Conduct: The Wales Accord of Sharing of Personal Information (WASPI) Code of Conduct (CoC) is a proposed annual assessment that the IG team will be required to complete to provide assurance against information sharing practices. The WASPI CoC proposal and consultation closes at the end of April 2023. The forecasted timeline proposes that the CoC will be live from Spring 2024, with planning being undertaken to ensure the IG team has provision to support this assessment going forward.

Local Reviews and Newly Developed Agreements: Over the last 12 months, 26 information sharing agreements have been completed. The team has seen a positive increase in the number of services voluntarily contacting the IG department for support with updating existing, or drafting new, information sharing agreements to support patient care with our external partners. The team has worked closely with services to review existing agreements and confirm if still required to ensure we meet our legislated obligations.

Data Protection Officer:

The Data Protection Officer (DPO) is responsible for ensuring that the application of data protection and confidentiality legislation is consistently observed, and any weaknesses in current practices are identified and remedied where possible. In 2018, the Health Board successfully implemented the General Data Protection Regulation and Data Protection Act (2018), alongside existing Confidentiality obligations. Since this time, the DPO has provided data protection advice across the Health Board. Common themes include clarity around internal and cross-organisational information sharing and assessing privacy risks. Updates and issues are discussed regularly with the Health Board's Medical Director/Caldicott Guardian and Senior Information Risk Owner (SIRO).

As Data Protection Officer the expectation is to see on-going maturity of the IG and Records Management Improvement Plans alongside clear IG and Records Strategy/obligations.

DISCLOSURE STATEMENTS

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Note 9.7 to the Annual Accounts provides details of the scheme, how it operates and the entitlement of employees.

Control Measures: Equality, Diversity and Inclusion

The organisation's approach to Equality, Diversity and Inclusion in 2022/2023 forms a key part of the Performance Report section of the Annual Report. The Equalities, Diversity and Inclusion Annual Report 2022-23 will be considered for approval at Board in July 2023.

Sustainability Report

Powys Teaching Health Board continues to support sustainability as a central organising principle. The importance of the environment agenda is reflected as a golden thread across the Integrated Medium-Term Plan (IMTP) for 2022-2025. The IMTP also supports the Health Board's endeavours to embed the principles of the Wellbeing of Future Generations

Act and the five ways of working. During 2022/2023 the organisation was successful in gaining re-certification to ISO14001 (2015) environmental management system standard and has successfully demonstrated its continued methodology and approach to environment management.

As part of the public sector obligation to become net zero by 2030, the Health Board reports annual quantitative carbon emissions. The Health Board submitted operational data for the 2021/2022 reporting period which calculated the total emission for the organisation as 24.12kt CO_2e, which is an increase over 2020/2021 data (17.02kt CO_2e). The Health Board's supply chain expenditure has increased from £39.9M in 2020/2021 to £63.3M in 2021/2022 (58.65% increase). This has correlated to a 41.66% equivalent carbon emission increase from 17,021 tCO_2e in 2020/2021 to 24,112 tCO_2e in 2021/2022.

Summary of carbon emissions

	Units of tCO_2e			
Categories	Scope 1	Scope 2	Scope 3	Total
Buildings, fleet & other assets	3,339.370	736.751	904.908	4,981.029
Business travel, commuting & homeworking	0	0	534.990	534.990
Waste	0	0	25.431	25.431
Land based emissions	0	0	-36.879	-36.879
Supply chain	0	0	18,539.810	18,539.810
				24,118.139

This is based predominately on financial expenditure and not detailed life cycle analysis, with investment across our estate impacting our emission levels. Increased Continuing NHS Healthcare (also known as CHC) spending has led to an increase in human health services. Minor Works expenditure increased as a result of our major capital investment projects, most notably the extensive renovation of Bro Ddyfi Community Hospital, the replacement of the roof in Ystradgynlais, the construction of a new staff car park in Brecon, the renovation of Basil Webb, and programmes to minimise ligature harm.

SIC Code	SIC Description	Expenditure		Subsequent emissions	
		2020-21	2021-22	2020-21	2021-22
81	Minor Works	£3,171,918	£16,285,649	779 tCO_2e	3,999 tCO_2e
86	Human Health Services	£19,086,758	£28,369,647	4,756 tCO_2e	7,070 tCO_2e

While the Health Board continues to repatriate services and implement our COVID-19 recovery plan, it is possible that health care spending may rise even further. Additionally, the 10-year capital investment programme will continue to see increases in carbon emissions in consecutive periods. Assurance can be given from the steady trajectory of our non-supply chain emissions which highlight a continued positive trend towards minimising carbon emissions and contributing towards a net zero public sector by 2030.

A major initiative is underway to engage with energy contractors to make energy efficiency savings across all buildings within our estate. The improvements are designed to cut carbon emissions, reduce energy usage and costs, improve building efficiency and control, introduce renewable energy generation and improve the quality of built environment for staff, patient and visitor wellbeing. The programme of construction works to introduce our innovative energy conservation measures will commence in 2023.

In compliance with our section 6 duty within Environment (Wales) Act, the Health Board produced and published its first Biodiversity Report. The report highlights progress made over the past three years and communicates our future plans including the Health and Social Care Climate Emergency-funded Biodiversity Enhancement and Protection project, which will be pivotal in the short, mid, and long-term protection and enrichment of biodiversity across all the Health Board's estate to ensure the Health Board responds accordingly to any identified biodiversity risks.

Data Security

A summary in relation to personal data incidents which required formal reporting to the Information Commissioner's Office (ICO) is provided on page 72 of this report.

Quality of Data used by the Board

The Health Board continually reviews the quality of data that it is using within the organisation including for decision making and assurance at Board level. Each of the separate data quality strands within the organisation are reviewed frequently that span across the main domains including finance, operational, workforce, quality, and safety data. However, it is a continuous process spanning an array of data systems and datasets including new systems being implemented. The Performance Report includes a Statement on Data Quality on page 12.

MINISTERIAL DIRECTIONS AND WELSH HEALTH CIRCULARS

Welsh Government has issued a number of Ministerial Directions in 2022/2023. A record of the Ministerial Directions given is available via the following link: https://gov.wales/health-social-care. A record of the Welsh Health Circulars is available via the following link: Health circulars | GOV.WALES

Receipt of Welsh Health Circulars are logged and a lead Executive Director identified to oversee the implementation of the required action or to develop the required response. The Audit, Risk and Assurance Committee received quarterly update reports on the implementation status of Welsh Health Circulars in 2022/2023. From this work it was evidenced that the Health Board was not impeded by any significant issues in implementing the actions required. This work is overseen by the Director of Corporate Governance / Board Secretary.

Appendices 3a/3b (p 90-95) provide an overview of Ministerial Directions and Welsh Health Circulars received during 2022/2023 and their implementation status as of March 2023.

Post Payment Verification

In accordance with the Welsh Government directions the Post Payment Verification (PPV) Team, (a role undertaken for the Health Board by the NHS Shared Services Partnership), in respect of General Medical Services Enhanced Services and General Ophthalmic Services has carried out its work under the terms of the service level agreement (SLA) and in accordance with NHS Wales agreed protocols. The Work of the Post Payment Verification Team is reported to the Board's Audit, Risk and Assurance Committee with papers available on the Health Board's website.

Review of Effectiveness

The National Health Service Finance (Wales) Act 2014 amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. The Act places two financial duties on Local Health Boards:

- a duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of three financial years; and
- a duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and

approved by the Welsh Ministers.

The 2022-2025 Integrated Medium-Term Plan was submitted to Welsh Government in March 2022 and approved by the Minister in July 2022. However, the Health Board has not been able to secure that its expenditure does not exceed the aggregate of the funding allocated to it over the three financial years from 2020-2023 as it is reporting a financial deficit of £7.002m in 2022/2023.

Planning, Delivery and Performance Framework

The organisation's Planning, Delivery and Performance Framework 2022/2023 forms a key part of the Performance Report section of the Annual Report. Further detail can be found in the Performance Report.

Review of Effectiveness of System of Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board receives assurance on the effectiveness of the system of internal control from a number of internal and external sources, these include:

- Delivery of Internal and External Annual Audit Plans;
- Audit Wales Structured Assessment;
- Audit Recommendation Tracking;
- Local Counter Fraud and Post Payment Verification Activity;
- Independent inspections and regulation provided by Health Inspectorate Wales;
- Engagement with Commissioners;
- Engagement with staff, patients, and other key stakeholders;
- Welsh Government review and advisement; and
- the Committees of the Board, in particular the Audit, Risk and Assurance Committee.

Internal Audit

Internal Audit provide me as Accountable Officer and the Board through the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal

audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The Head of Internal Audit Annual Opinion provides assurance on governance, risk management and the system of internal control and is based on the risk-based audit programme. The opinion contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement. A summary of the Head of Internal Opinion 2022/2023 is provided below.

Head of Internal Audit Opinion for 2022/2023

At the time this report was compiled the draft Head of Internal Audit Opinion for 2022/23 had been received with the following overall opinion:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

The Head of Internal Audit to provide a statement for the final version of the Accountability Statement.

The summary of Internal Audits for 2022/23 received to date is as follows:

(Table to be replaced when final report received)

Substantial Assurance	Reasonable Assurance
• Control of Contractors: Follow-up • Looked After Children Health Assessments • Cancer Services - Access to Symptomatic FIT • Women & Children's Services	• Staff Rostering • Security Services • Machynlleth Hospital Reconfiguration Project • North Powys Wellbeing Programme • Charitable Funds • Workforce Futures Strategic Framework • Incident Management • Therapies and Health Sciences Professional Governance Structure • Temporary Staffing Department • Risk Management and Board Assurance Framework (Draft) • Performance Management & Reporting (Draft) • Occupational Health Follow-up (Draft)
Limited Assurance	**Advisory & Non-Opinion**
• IT Infrastructure and Asset Management • Welsh Language Standards • Cyber Security	• Site Leadership & Coordination • Decarbonisation
No Assurance	**Assurance yet to be determined**
N/A	• Savings Plans / Efficiency Framework (WiP) • Follow-up Action Tracker (WiP) • SLAs for IN-reach Medical Staff (WiP)

Limited Assurance Rated Reviews

Three Limited assurance rated reviews had been received during 2022/23. The reports were in respect of:

- IT Infrastructure and Asset Management;
- Welsh Language Standards, and
- Cyber Security

All Limited Assurance Rated Reviews are reported to Welsh Government on a quarterly basis in addition to our own internal reporting and monitoring arrangements.

Counter Fraud

In line with the Government Functional Standard 013 Counter Fraud NHS Requirements the Local Counter Fraud Specialist (LCFS) and Executive Director of Finance agreed a work plan for 2022/2023 at the beginning of

the financial year. This was approved by the Audit, Risk and Assurance Committee in March 2022.

Following introduction of Government Functional Standards on Counter Fraud, which replaced NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)' from 2021/2022, the Health Board's Counter Fraud Workplans have been aimed at ensuring compliance for the first enforcement year of the new standards in 2023/2024. To assess compliance, the Health Board is required to submit an annual self-assessment Functional Standard Return on a RAG rated basis to NHS Counter Fraud Authority.

Good progress has been made since the introduction of the new Standards and this is reflected in continuing improvements to RAG ratings for each Standard in self assessed Functional Standard Returns throughout the last two financial years. There are two Standards Components that are still not Green rated at the end of 2022/2023 however;

Component 1B - Accountable individual - rated Amber

This Standard is currently rated Amber due to the Health Board only recently nominating a Fraud Champion to the role. The Health Board's Director of Corporate Governance was identified as the most suitable Senior Officer to meet the requirements of the Fraud Champion role and a nomination was subsequently completed. An action plan has been set for Fraud Champion activity for 2023/2024 which includes support in enabling managing fraud risks via the existing Health Board mechanisms, providing strategic support around our reporting of counter fraud work, and communications around gifts and hospitality/declarations of interests. This activity will result in Green rating within the next review.

Component 3 - Fraud bribery and corruption risk assessment - rated Amber

This Component is currently rated as Amber due to the requirements for maturity of this area of work to enable demonstration of continuous monitoring of fraud risk at a senior level, evidence of subsequent risk mitigation and that review of resources has been undertaken to ensure levels are suitable for this purpose.

Since introduction of this Component the Counter Fraud Team have sought to establish the fraud risk assessment processes aligned to the Health Board's existing Risk Management procedures.

The Team have then created a core fraud risk profile developed from 129 NHS fraud risk descriptors. Alongside this, further scanning has been

undertaken to capture and manage emerging fraud risks such as arising from investigation, Fraud Prevention Notices, local intelligence, audit reports and findings, and NHS CFA IBURN releases. A tracker has been created to track and manage the actions around these known and emerging fraud risks.

LCFSs have subsequently sought to undertake comprehensive risk assessments in liaison with local risk owners to establish a core foundation of assessments to work from. Arrangements have been made to record those risks on the DATIX system which will be utilised from 2023/2024 to manage, track and measure fraud risk within the Health Board.

Use of the DATIX system, alongside the local tracker, will allow evidence to be developed to meet the remaining elements outstanding to uplift this Component to Green.

Improvement activity for these areas is included within the 2023/2024 Counter Fraud Work Plan. Further detail can be found in the Counter Fraud Annual Report for 2022/2023, which will be presented to the Audit, Risk and Assurance Committee.

Audit Wales Structured Assessment

At the time this report was compiled the Audit Wales Structured Assessment was yet to be finalised, this aspect of the report will be included in due course.

MODERN SLAVERY ACT 2015: TRANSPARENCY IN SUPPLY CHAINS

The Welsh Government's Code of Practice: Ethical Employment in Supply Chains was published in May 2017 to highlight the need, at every stage of the supply chain, to ensure good employment practices exist for all employees, both in the UK and overseas. It is expected that all NHS Wales organisations will sign up for the Code.

The Health Board fully endorses the principles and requirements of the Code and the Modern Slavery Act 2015 and is committed to playing its role as a major public sector employer, to eradicate unlawful and unethical employment practices, such as:

- modern Slavery and Human rights abuses;
- the operation of blacklist/prohibited lists;
- false self-employment;
- unfair use of umbrella schemes and zero hours' contracts; and
- paying the Living Wage.

The following actions are already in place which meet the Code's commitments:

- We follow the All-Wales procedure for staff to raise concerns (Whistleblowing), which provides the workforce with a fair and transparent process, to empower and enable them to raise suspicions of any form of malpractice by either our staff or suppliers/contractors working on University Health Board premises.
- We have a target in place to pay our suppliers within 30 days of receipt of a valid invoice.
- We comply with the six NHS pre-employment check requirements to verify that applicants meet the preconditions of the role they are applying for. This includes a right to work check.
- We do not engage or employ staff our workers on zero hours' contracts.
- We have an Equality, Diversity and Human Rights Policy in place which ensures that no potential applicant, employee, or worker engaged is in any way unduly disadvantaged in terms of pay, employment rights, employment, or career opportunities.
- We also seek assurances from suppliers, via the tender process, that they do not make use of blacklists/prohibited lists. We also require confirmation and assurances that they do not make use of blacklist/prohibited list information.
- In accordance with Transfer of Undertaking (Protection of Employment) Regulations any Health Board staff member who may be required to transfer to a third party will retain their NHS Terms and Conditions of

Service.

- We use the Modern Slavery Act (2015) compliance tracker by way of contracts procured by NHS Wales Shared Services Partnership (NWSSP) on behalf of the Health Board. NWSSP is equally committed to ensuring that procurement activity conducted on behalf of NHS Wales is undertaken in an ethical way. On our behalf, they ensure that workers within the supply chains through which they source our goods and services are treated fairly, in line with Welsh Government's Code of Practice for Ethical Employment in Supply Chains.

The Health Board continues to work in partnership with relevant stakeholders and trade union partners to develop and implement actions which set out our commitment to ensure the principles of ethical employment within our supply chains are implemented and adhered to.

Conclusion

As Accountable Officer for Powys Teaching Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board including its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place, during the year, a system of providing assurance aligned to corporate objectives to assist with identification and management of risk. I am pleased to note that as a result of our internal control arrangements, Powys Teaching Health Board continues to be on 'routine' monitoring as part of NHS Wales Escalation and Intervention arrangements during 2022/2023.

During 2022/2023, we proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Further work will be undertaken in 2023/24 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will continue in 2023/2024 to embed risk management and the assurance framework at a corporate level. Implementation of the Board's Annual Governance Programme will see a further strengthening of the Board's effectiveness and the system of internal control in 2023/2024.

This Annual Governance Statement confirms that Powys Teaching Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board including the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board and Director of Corporate Governance, I will continue to drive improvements and will seek to provide assurance for our

citizens and stakeholders that the services we provide are efficient, effective, and appropriate, and are designed to meet patient needs and expectations.

Appendix 1: Board and Board Committee Membership and Attendance at Board

Name	Position and Area of Expertise	Board and Board Committee Membership	Attendance 2022-23	Board Champion Role
Vivienne Harpwood	Chair (To 16 October 2022)	▪ Chair of the Board	5/5	
		▪ Chair of the Charitable Funds Committee	2/2	
		▪ Chair of the Remuneration and Terms of Service Committee	3/3	
Carl Cooper	Chair (From 17 October 2022)	▪ Chair of the Board	4/4	
		▪ Chair of the Charitable Funds Committee	3/3	
		▪ Chair of the Remuneration and Terms of Service Committee	4/4	
Kirsty Williams	Vice Chair	▪ Vice Chair of the Board	8/9	• Infection Prevention and Control • Armed Forces and Veterans • Mental Health • Children and Young People
		▪ Chair of the Patient Experience, Quality and Safety Committee	5/5	
		▪ Vice Chair of the Remuneration and Terms of Service Committee	7/7	
		▪ Member of the Delivery and Performance Committee	5/5	
		▪ Member of the Planning, Partnerships and Population Health Committee	2/4	
Ian Phillips	Independent Member [Information Technology]	▪ Member of the Board	8/9	
		▪ Member of the Patient Experience, Quality and Safety	4/4	
		▪ Chair of the Workforce and Culture Committee	3/3	
		▪ Vice Chair of the Planning, Partnerships and Population Health Committee	4/4	
		▪ Remuneration and Terms of Service Committee	7/7	
Jennifer Owen-Adams	Independent Member [Third Sector]	▪ Member of the Board	4/5	
		▪ Vice Chair of the Patient Experience, Quality and Safety Committee	2/3	

	(From 30 August 2022)	▪ Member of the Workforce and Culture Committee	½	
		▪ Member of the Planning, Partnerships and Population Health Committee	2/2	
Matthew Dorrance	Independent Member [Local Authority] (To 30 June 2022)	▪ Member of the Board	2/3	• Equality
		▪ Member of the Audit, Risk and Assurance Committee	1/3	
		▪ Vice Chair of the Workforce and Culture Committee	0/1	
Chris Walsh	Independent Member [Local Authority] (Active from 01 January 2023)	▪ Member of the Board	2/3	
		▪ Member of Workforce and Culture Committee	0/0	
Rhobert Lewis	Independent Member [General]	▪ Member of the Board	9/9	
		▪ Vice Chair of the Charitable Funds Committee	5/5	
		▪ Member of the Audit, Risk and Assurance Committee	7/8	
		▪ Chair of the Planning, Partnerships and Population Health Committee	4/4	
		▪ Member of the Delivery and Performance Committee (from 11 November 2022)	2/2	
		▪ Provided cover at Workforce and Culture 20/09/2022	1/1	
Tony Thomas	Independent Member [Finance]	▪ Member of the Board	5/9	
		▪ Vice Chair of the Audit, Risk and Assurance Committee (Chair to 18 July 2022 Vice Chair)	6/8	
		▪ Member of the Remuneration and Terms of Service Committee	3/7	
		▪ Vice Chair of the Delivery and Performance Committee	2/5	
Mark Taylor	Independent Member [Capital and Estates]	▪ Member of the Board	8/9	
		▪ Chair of the Audit, Risk and Assurance Committee (Vice Chair to 18 July 2022 then Chair)	8/8	

		▪ Member of the Remuneration and Terms of Service Committee	6/7	
		▪ Member of the Patient Experience, Quality and Safety Committee	3/5	
		▪ Chair of the Delivery and Performance Committee	5/5	
Frances Gerrard	Independent Member [University] (To 30 June 2022)	▪ Member of the Board	1/3	
		▪ Member of the Charitable Funds Committee	1/1	
		▪ Member of the Patient Experience, Quality and Safety Committee	1/1	
Simon Wright	Independent Member [University] (From 08 August 2022)	▪ Member of the Board	4/5	
		▪ Member of the Patient Experience, Quality and Safety Committee	2/3	
Ronnie Alexander	Independent Member [General]	▪ Member of the Board	7/9	
		▪ Member of the Audit, Risk and Assurance Committee	7/8	
		▪ Vice Chair of the Delivery and Performance Committee	5/5	
		▪ Member of Workforce and Culture Committee (From 31 May 2022 to January 2023)	2/3	
		▪ Member of Planning, Partnerships and Population Health Committee	4/4	
Cathie Poynton	Independent Member [Trade Union]	▪ Member of the Board	8/9	
		▪ Member of the Workforce and Culture Committee	3/3	
		▪ Member of the Charitable Funds Committee	3/3	
		▪ Member of the Delivery and Performance Committee	5/5	
Carol Shillabeer	Chief Executive	▪ Board	9/9	
Hayley Thomas	Deputy Chief Executive and Interim Director of Primary, Community Care and Mental Health	▪ Board	7/9	
Pete Hopgood	Director of Finance, IT and Information Services	▪ Board	8/9	
Kate Wright	Medical Director	▪ Board	6/9	• Caldicott

Claire Roche	Director of Nursing and Midwifery	▪ Board	9/9	• Children and Young People • Putting Things Right
Claire Madson	Director of Therapies and Health Sciences	▪ Board	7/9	
Stephen Powell	Interim Director of Planning and Performance	▪ Board	9/9	
Mererid Bowley	Interim Director of Public Health	▪ Board	5/6	• Emergency Planning
Julie Rowles	Director of Workforce and Organisational Development	▪ Board	1/1	
Debra Wood-Lawson	Interim Director of Workforce and Organisational Development	▪ Board	3/4	
James Quance	Board Secretary	▪ Board	6/6	
Helen Bushell	Director of Corporate Governance / Board Secretary	▪ Board	3/3	

The Board Champion for Health and Safety during 2022/23 was Jamie Marchant, Director of Environment.

Appendix 2: Table of Quoracy

Board/Committee	Dates:									Quorate
Board	28 April 2022	25 May 2022	14 June 2022	27 July 2022	28 September 2022	30 November 2022	25 January 2023	20 February 2023	29 March 2023	Yes
Charitable Funds	14 June 2022	23 September 2022	07 December 2022	16 January 2023	01 March 2023					Yes
Remuneration and Terms of Service	12 April 2022	28 July 2022	26 September 2022	05 December 2022	31 January 2023	6 March 2023	29 March 2023			Yes
Planning, Partnerships and Population Health Committee	07 April 2022	14 July 2022	20 October 2022	19 January 2023						Yes
Patient Experience, Quality and Safety Committee	12 May 2022	29 July 2022	13 September 2022	24 November 2022	23 February 2023					Yes
Delivery and Performance Committee	03 May 2022	23 June 2022	12 September 2022	11 November 2022	28 February 2023					Yes
Audit, Risk and Assurance Committee	26 April 2022	17 May 2022	12 June 2022	18 July 2022	27 September 2022	31 January 2023	21 March 2023			Yes
Workforce and Culture Committee	31 April 2022	20 September 2022	13 December 2022							Yes

Appendix 3a: Welsh Health Circulars 2022/2023

Welsh Health Circular	Date/Year of Adoption	Action to Demonstrate Implementation/Response	Status
2022-009 Prioritisation of COVID-19 patient episodes by NHS Wales Clinical Coding Departments	April 2022	WHC actioned and implemented	Complete
2022-015 Changes to the vaccine for the HPV Immunisation Programme	May 2022	This WHC has been superseded by WHC-2022/2023	N/A
2022-016 The National Influenza Vaccination Programme 2022-23	June 2022	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 offering to all eligible groups (bar Health & social care staff/care home residents). Delivery of remaining Covid-19 to eligible 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 22/early September 22 to discuss COVID-19 programme delivery and confirmation letter sent to each individual practice outlining programme expectations and support available.	In Progress
2022-002 NHS Wales National Clinical Audit and Outcome Review Plan. Annual Rolling Programme for 2022-2023	June 2022	Complete but with acknowledgement that participation in audits will be improved in 23/24: The Podiatry service is participating in the National Diabetes Foot Care audit and the collection of data for the audit is on-going. An action plan will be published following the release of the national report. PTHB has re-established its pulmonary rehabilitation offer and intends to continue to participate in future audits.	Complete
2022-019 Non-Specialised Paediatric Orthopaedic Services	June 2022	Implementation not yet due as of April 2023	Not Yet Due
2022-012 Donation and Transplantation Plan for Wales 2022-2026	June 2022	Implementation not due until December 2026	Not Yet Due
2022-018 Guidelines for managing patients	June 2022	PTHB provides limited diagnostic services for cancer and minimal treatments as the majority	In Progress

on the suspected cancer pathway		of Powys residents with suspected cancer are managed by commissioned provider services in England and Wales. Referral to treatment times are the responsibility of the Director of Planning and Performance for Commissioned Services and the Director of Primary, Community Care and Mental Health for directly provided services. Performance is monitored through the Integrated Performance Framework for the Health Board and regularly reported to the Board and relevant committees. The Cancer Renewal Programme has established a Harm Review Panel to review harm reviews undertaken by other Health Boards and NHS trusts treating Powys patients.	
2022-006 Direct Paramedic referral to same day emergency care	April 2022	Emergency/acute care not commissioned within Powys. However, a range of actions being taken as defined in the Integrated Care Action Plan (ICAP), fully integrated with 6 Goals delivery, and reviewed in monthly monitoring arrangements. Ongoing work with commissioned partners to ensure quality, safe and timely care in Emergency Departments – annual cycle, alongside daily engagement with operational flow across National urgent care system.	In Progress
2022-017 Wales Rare Diseases Action Plan 2022-2026	June 2022	We plan to ensure representation via the specialised service lead, but this post is not yet appointed. 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. The Health Board is working to create a Specialised Pathway Lead post.	In Progress
2022-022 Role of the Community Dental Service and Services for vulnerable people	August 2022	Recruited 1 WTE salaried GDP to provide routine GDS services, o.6WTE vacancy for specialist in special care dentistry. Looking to use a cloud-based service to improve IT record systems within the CDS. Recruitment of Paediatric specialist for 3 sessions per month to improve governance and service. Skill mixing using direct access therapists	In Progress
2022-021 National Optimal Pathways for Cancer	July 2022	PTHB provides limited diagnostic services for cancer and minimal treatment. The majority of Powys residents with suspected cancer are managed by commissioned NHS services. In the Powys context the optimal pathways apply across organisational boundaries involving services provided by other Health Boards in	In Progress

		Wales and also services provided by NHS trusts in England. Executive leads for cancer need to use the optimal pathways to support planning and design of pathways. The Wales Cancer Network has appointed two posts managed centrally to work with PTHB on mapping the optimal pathways. However, the first stage produced highly generalised information which was of limited value. At present only the Welsh flows are included but to be meaningful for Powys this must also include its English flows so further work is being undertaken with the network.	
2022-020 Never Events Policy and Incident List	July 2022	Never Events are reported to Patient Experience, Quality and Safety (PEQS) Committee on a quarterly basis; to note there have not been any Never Events in the last 18months.	Complete
2022-023 Changes to the Vaccines for the HPV Immunisation Programme	September 2022	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'.	Complete
2022-003 Guidance for the provision of continence containment products for Adults in Wales	October 2022	We have Band 6 Continence Promotion Practitioners. Waiting list around 8 weeks. They assess patients and from their assessment pads may or may not be provided. We are an assessment/ treatment service and pads are provided on need and according to bladder and bowel dysfunction. We have a triage system for referrals so end of life patients for example are assessed and pads provided if required within 48 /72 hours. For children, the appropriate person assesses, e.g., children's nurse, school nurse etc. and pads are then allocated again according to need.	Complete
2022-004 Guidance for the care of Children and young people with continence problems	October 2022	The service is completing the SOP which will incorporate the guidance – the deadline for completion has overrun but is expected for completion this quarter. The review of the list of the children in receipt of containment products against the guidance is outstanding this has been requested again as a priority for completion this quarter.	In Progress
2022-027 & 2022-029 Urgent polio catch up programme for children under 5 years old	October 2022	Director of Public Health has contacted the Primary care Team to ask them to send the letter to GP Practices to ask who wishes to participate in catch-up, with deadline of 09 Nov 22 for returns. All GP Practices participating in catch-up and underway.	In Progress
2022-026 Approach for respiratory viruses-Technical guidance for healthcare planning	October 2022	11 October 2022 letter from Director of Public Health to all GP Practices/Pharmacies (sent via pharmacy and Primary care leads). Agenda item on Executive Committee meeting on 19 October 2022. Letter to all HB staff inviting for co-administering Covid-19 & flu vaccinations	In Progress

		commencing week of 10/10/22. Joint Message to all staff from four Executive clinical leads to encourage vaccination & how to access covid & flu vaccines (communicated via Powys News and carousel) (live on carousel from 26/10/22). Chief Executive to include message on vaccination in all staff briefing on 26 October 2022. Pathway and triage processes in place, led by pharmacy, to access antivirals. Pathway reviewed regularly jointly by Chief Pharmacist, Medical Director, Director of Public Health & Assistant Director of Community Services. Testing pathways in place.	
2022-013 Monthly Financial monitoring return guidance	April 2022	The Health Board is meeting WG guidance in respect of reporting its financial performance to Welsh Government.	Complete
2022-008 New records management code of practice for health and care 2022	April 2022	Implementation not yet due as of May 2023.	Not Yet Due
2022-028 More than just words Welsh Language Awareness Course	November 2022	The Welsh Awareness Training Course is now included within statutory and mandatory training through ESR. Compliance will be monitored through the workforce performance reporting alongside all other statutory and mandatory training, Compliance as at 17.2.23 is 60.93%.	Complete
2022-031 Reimbursable vaccines and eligible cohorts for the 2023/24 NHS seasonal Influenza (flu) Vaccination Programme	December 2022	Chief Pharmacist and Assistant Director of Primary Care circulated letter to GP Practices and Community pharmacy and for ordering of HB stocks. Further guidance received to community pharmacy & GPs. Additional actions as per flu update.	In Progress
2022-035 Influenza (flu) Vaccination Programme deployment 'mop up' 2022-2023	December 2022	Walk ins in place from early January for all eligible residents at all 3 MVCs. Promoted at least weekly through Health Board comms channels. Proactive MECC approach to all eligible attendees attending for COVID-19 vaccination.	Complete
2023-001 Eliminating Hepatitis B and C as a Public Health threat in Wales – actions for 2022-2023 and 2023-2024	January 2023	Implementation not yet due as of end of March 2023	Not Yet Due
2023-002 New Lower Gastrointestinal 'FIT' National optimal Pathway 	January 2023	All general practices now have access to symptomatic Faecal Immunochemical Test (FIT) services where there is a suspicion of colorectal cancer. The new Lower Gastrointestinal 'FIT' National Optimal Pathway documentation has been distributed to Powys General Practices. The PTHB Cancer Clinical Lead has worked closely with Cluster Leads and GP Collaboratives to ensure they are up to date with Faecal Immunochemical Test pathways and the National Optimal Pathway for FIT including highlighting the importance of 'safety netting'.	Complete

		An Internal Audit conducted in October 2022 concluded there was substantial assurance with regard to the controls and processes in place and that the planned actions to allow improved access to symptomatic FIT are being effectively delivered. This is now 'business as usual' with no further action required.	
2022-034 Health Board 2023-2024 Allocations	December 2022	Implementation not yet due as of end of March 2023	Not Yet Due
2023-004 Covid-19 Spring Booster Vaccination Programme 2023	March 2023	Implementation not yet due as of June 2023	Not Yet Due
2022-032 Further extending the use of Blueteq in secondary care	March 2023	Implementation not yet due as of April 2023	Not Yet Due
2023-007 Patient Testing Framework-Updated Guidance	March 2023	Framework due to be reviewed in June 2023 (depending on public health indicators)	Not Yet Due
2023-003 Guidelines for the investigation of moderate or severe early developmental impairment or intellectual disability (EDI/ID)	April 2023	Guideline to be reviewed in May 2023	Not Yet Due
2023-006 Commencement of the Health and Social Care (Quality and Engagement (Wales) Act 2020	March 2023	To be reviewed in April 2023	Not Yet Due

Appendix 3b: Ministerial Directions 2022-23

Ministerial Directions (MDs)	Date/Year of Adoption	Action to demonstrate implementation/response	Status
Ministerial Direction 1 Our Programme for transforming and modernising planned care and reducing waiting lists in Wales	April 2022	Implementation not yet due as of April 2026	Not Yet Due
Ministerial Direction 2 Financial Entitlements Amendments	June 2022	Completed as per the date of issue/effective from and would have been discharged for us via Business Services Unit who pay Primary Care contractors on all Health Board behalf.	Complete
Ministerial Direction 3 The Primary care (contracted Services Immunisations)	August 2022	Implementation not yet due.	Not Yet Due

PART B: REMUNERATION AND STAFF REPORT

This report contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc and has been compiled by the Directorate of Finance, Information & IT and the Workforce and Organisational Development Directorate

Background

The remuneration and staff report sets out the organisation's remuneration policy for Executive Directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to Executive Directors and senior managers and where relevant the link between performance and remuneration. The FReM requires that a Remuneration Report shall be prepared under the headings in SI2008 No 410 to the extent that they are relevant. The definition of "Senior Managers" for these purposes is:

"those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual Executive Directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration Terms of Service Committee

Remuneration and terms of service for Executive Directors and the Chief Executive are agreed and kept under review by the Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Executive Directors (the latter with the advice of the Chief Executive).

In 2022/2023, the Remuneration and Terms of Services Committee was chaired by the Health Board's Chair, firstly Vivienne Harpwood (to 15 October 2022) followed by Carl Cooper (from 17 October 2022), and the membership included the following Independent Members:

- Kirsty Williams, Vice Chair of the Board
- Tony Thomas, Independent Member (Finance)
- Mark Taylor, Independent Member (Capital and Estates)
- Ian Phillips, Independent Member (ICT)

Meetings are minuted and decisions fully recorded.

The meeting is attended by the Chief Executive, Director of Workforce and Organisational Development and Director of Corporate Governance / Board Secretary with appropriate corporate governance support.

Independent Members' Remuneration

Remuneration for Independent Members is decided by the Welsh Government, which also determines their tenure of appointment.

Directors' and Independent Members' Remuneration

Details of Directors' and Independent Members' remuneration for the 2022/23 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2022/23, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Committee also seeks assurance from the Chief Executive in relation to Executive team objectives and performance when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions were set by Welsh Government as part of the NHS Reform Programme of 2009.

For part of the year there were a number of interim Directors in post including; an Interim Director of Public Health, Interim Director of Workforce and Organisational Development, Interim Director of Planning and Performance, Interim Director of Primary, Community Care and Mental Health and Interim Board Secretary.

Table 1: Salary and Pension Disclosure Table: Salaries and Allowances, single total figure of Remuneration

	2022 - 23						2021 - 22					
Name and title	Salary (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (to nearest £100) £00	Pension Benefits (to nearest £1000) £000	Single Total Remuneration (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Salary (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (to nearest £100) £00	Pension Benefits (to nearest £1000) £000	Single Total Remuneration (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000
Executive directors												
Carol Shillabeer - Chief Executive	175 - 180	0	0	29	205 - 210	0	175 - 180	0	0	61	235 - 240	0
Hayley Thomas - Director of Planning and Performance and Deputy Chief Executive (to 31st March 2022) and Director of Primary Care, Community and Mental Health (from 1st April 2022) **	125 - 130	0	0	26	155 - 160	0	125 - 130	0	0	59	180 - 185	0
Stephen Powell - Interim Director of Planning and Performance)from 1st April 2022)	115 - 120	0	0			0	0	0	0	0	0	0
Pete Hopgood - Director of Finance, Information and IT Services * and **	120 - 125	0	0	0	120 - 125	0	115 - 120	0	0	56	170 - 175	0
Julie Rowles - Director of Workforce and OD (To 3rd February 2023) and (Support Services until 1st December 2021)	130 - 135	0	0	45	175 - 180	0	120 - 125	0	19	58	175 - 180	0
Debra Wood Lawson - Interim Director of Workforce and OD (from 3rd October 2022)	70 - 75	0	0	7	75 - 80	0	0	0	0	0	0	0
Kate Wright - Medical Director	140 - 145	0	0	8	145 - 150	0	140 - 145	0	0	109	250 - 255	0
Claire Madsen - Director of Therapies and Health Science **	105 - 110	0	0	33	140 - 145	0	100 - 105	0	0	34	135 - 140	0
Stuart Bourne - Director of Public Health (To 11th March 2022) ****	0	0	0	0	0	0	100 - 105	0	0	41	145 - 150	0
Mererid Bowley - Director of Public Health (from 27th June 2022)	115 - 120	0	0	46	160 - 165	0	0	0	0	0	0	0
Alison Davies - Director of Nursing and Midwifery (To 14th March 2022) ****	0	0	0	0	0	0	110 - 115	0	0	41	155 - 160	0
Clare Roche - Director of Nursing and Midwifery (From 7th March 2022)* and ****	115 - 120	0	0	34	150 - 155	0	5 - 10	0	0	4	10 - 15	0
Jamie Marchant - Director of Primary, Community Care and Mental Health Services (To 1st December 2021) - Director of Environment (From 1st December 2021) *	110 - 115	0	0	0	120 - 125	0	115 - 120	0	0	9	120 - 125	0
Rani Mallison - Board Secretary (To 27th November 2021) * & *** & ****	0	0	0	0	0	0	60 - 65	0	0	21	85 - 90	0
James Quance - Board Secretary (From 4th January 2022 to 31st December 2022) * & ****	70 - 75	0	0	18	90 - 95	0	20 - 25	0	0	0	20 - 25	0
Helen Bushell - Director of Corporate Governance and Board Secretary (from 9th January 2023)	20 - 25	0	0	5	25 - 30	0	0	0	0	0	0	0
Associate Members												
Nina Davies - Interim Director of Social Serices and Housing, Powys County Council (from 1st January 2023)	0	0	0	0	0	0	0	0	0	0	0	0
Chair of Healthcare Professionals Forum (TBC)	0	0	0	0	0	0	0	0	0	0	0	0
Chair of Stakeholder Reference Group (TBC)	0	0	0	0	0	0	0	0	0	0	0	0

Name and title	2022 - 23 Salary (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (to nearest £100) £00	Pension Benefits (to nearest £1000) £000	Single Total Remuneration (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	2021 - 22 Salary (bands of £5,000) £000	Bonus Payments (bands of £5,000) £000	Benefits in Kind (to nearest £100) £00	Pension Benefits (to nearest £1000) £000	Single Total Remuneration (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000
Non-Officer Members												
Professor Vivienne Harpwood - Chair (to 16th October 2022)	20 - 25	0	0	0	20 - 25	0	40 - 45	0	0	0	40 - 45	0
Carl Cooper - Chair (from 17th October 2022)	20 - 25	0	0	0	20 - 25	0	0	0	0	0	0	0
Melanie Davies - Vice Chair (to 26th December 2021) -----	0	0	0	0	0	0	25 - 30	0	0	0	25 - 30	0
Kirsty Williams - Vice Chair (from 10th January 2022) -----	35 - 40	0	0	0	35 - 40	0	5 - 10	0	0	0	5 - 10	0
Anthony Thomas - Independent Member (Finance)	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Matthew Dorrance - Independent Member (Local Authority to 30th June 2022)	0 - 5	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Patricia Buchan - Independent Member (Third Sector - to31st March 2022)	0	0	0	0	0	0	5 - 10	0	0	0	5 - 10	0
Frances Gerrard - Independent Member (University held post relating to health to 30th June 2022)	0 - 5	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Ian Phillips - Independent Member (ICT)	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Susan Newport - Independent Member (Trade Union to 30th September 2021)	0	0	0	0	0	0	0	0	0	0	0	0
Cathie Poynton - Independent Mmeber (Trade Union from 11th November 2021)	0	0	0	0	0	0	0	0	0	0	0	0
Mark Taylor - Independent Member (Capital and Estates)	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Rhobert Lewis - Independent Member (General)	5 - 10	0	0	0	10 - 15	0	10 - 15	0	0	0	10 - 15	0
Ronnie Alexander - Independent Member (General from 21st June 2021)	5 - 10	0	0	0	5 - 10	0	5 - 10	0	0	0	5 - 10	0
Chris Walsh - Independent Member (Local Authority - from 1st November 2022)	0 - 5	0	0	0	0 - 5	0	0	0	0	0	0	0
Jennifer Owen Adams - Independent Member (Third Sector - from 30th August 2022)	5 - 10	0	0	0	5 - 10	0	0	0	0	0	0	0
Simon Wright - Independent Member (University held post relating to health - from 8th August 2022)	5 - 10	0	0	0	5 - 10	0	0	0	0	0	0	0

Information awaited to enable completion

* Please note that the salary for Jamie Marchant includes £9,000 sacrificed in relation to a leased car (in 2021-22 the figure was £10,000), the salary for Rani Mallison includes £0 sacrificed in relation to a leased car (in 2021/22 the figure was £4,000), the salary for James Quance includes £1,000 in relation to a leased car (in 2021/22 the figure was £1,000) the salary for Pete Hopgood includes £7,000 in relation to a leased car (in 2021/22 the figure was £0) and the salary for Clare Roche includes £1,000 in relation to a leased car (in 2021/22 the figure was £0).

** Please note that the portfolio of the Director of Primary, Community and Mental Health Services was split for a period and allocated to three Executive Directors from 1st December 2021 to 31st March 2022. The portfolio was split as follows; Pete Hopgood Primary Care; Hayley Thomas Community Care and Clare Madsen Mental Health Services'; no additional remuneration was paid to these Directors as a result of the additional responsibilities.

*** Please note that there was an agreement for Rani Mallison to work for Aneurin Bevan University Health Board for 1 day a week from 1st November 2021.

**** Please note that the full year equivalent salary banding, in bands of £5,000, for starters and leavers during 2022/23 was as follows; James Quance £90,000-£95,000, Julie Rowles £120,000 - £125,000, Debra Lawson Wood, Mererid Bowley, Helen Bushell £105,000 - £110,000

***** Please note that salary overpayments have been identified during 2021/22 and these are still being recovered.

The value of pension benefits is calculated as follows: (real increase in pension* x20) + (real increase in any lump sum*) – (contributions made by member) * excluding increases due to inflation or any increase or decrease due to a transfer of pension rights.

The remuneration report now contains a Single Total Figure of remuneration, this is a different way of presenting the remuneration for each individual for the year. The table used is similar to that used previously, and the salary and benefits in kind elements are unchanged. The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The Single Total Figure of remuneration is not an amount which has been paid to an individual by the THB during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g., changes in a person's salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The 2022-23 financial year is the second-year disclosures in respect of the 25th percentile pay ratio and 75th percentile pay ratio are required

		2022-23	2022-23	2022-23		2021-22	2021-22	2021-22
		£000	£000	£000		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		**Chief Executive**	**Employee**	**Ratio**
	25th percentile pay	177	25	7.1:1		177	22	8.0:1
	Median pay	177	33	5.4:1		177	32	5.5:1
	75th percentile pay ratio	177	43	4.1:1		177	41	4.3:1
Salary component of total pay and benefits								
	25th percentile pay	177	25			177	22	8.0:1
	Median pay	177	33			177	32	5.5:1
	75th percentile pay ratio	177	43			177	41	4.3:1
		Highest Paid				**Highest Paid**		
Total pay and benefits		**Director**	**Employee**	**Ratio**		**Director**	**Employee**	**Ratio**
	25th percentile pay	177	25	7.1:1		177	22	8.0:1
	Median pay	177	33	5.4:1		177	32	5.5:1
	75th percentile pay ratio	177	43	4.1:1		177	41	4.3:1
Salary component of total pay and benefits								
	25th percentile pay	177	25			177	22	8.0:1
	Median pay	177	33			177	32	5.5:1
	75th percentile pay ratio	177	43			177	41	4.3:1

In 2022-23, 2 (2020-21, 2) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £20,758 to £217,294 (2021-22, £18,576 to £188,839).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Percentage Changes:

9.6.2 Percentage Changes		2021-22	2020-21
		to	to
		2022-23	2021-22
% Change from previous financial year in respect of Chief Executive		%	%
	Salary and allowances	2	3
	Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director			
	Salary and allowances	2	3
	Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole			
	Salary and allowances	5	5
	Performance pay and bonuses	0	0

Table 2: Salary and Pension Disclosure

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 Mar 2023 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st Mar 2023 (bands of £5,000) £000	Cash Equivalent transfer value at 31 Mar 2023 £000	Cash Equivalent transfer value at 31 Mar 2022 Restated £000	Real increase in Cash Equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Carol Shillabeer - Chief Executive	2.5 - 5.0	(0.0) - (2.5)	70 - 75	150 - 155	1,353	1,253	36	0
Hayley Thomas - Director of Planning and Performance and Deputy Chief Executive (to 31st March 2022) and Director of Primary Care, Community and Mental Health (from 1st April 2022)	0.0 - 2.5	(0.0) - (2.5)	40 - 45	75 - 80	718	657	22	0
Pete Hopgood - Director of Finance, Information and IT Services	0.0 - 2.5	(5.0) - (7.5)	45 - 50	90 - 95	837	804	-7	0
Julie Rowles - Director of Workforce and OD (To 3rd February 2023) and (Support Services to 1st December 2021)	2.5 - 5.0	(2.5) - (5.0)	65 - 70	145 - 150	1,413	1,307	51	0
Kate Wright - Medical Director	0.0 - 2.5	(2.5) - (5.0)	35 - 40	50 - 55	665	622	5	0
Claire Madsen - Director of Therapies and Health Science	0.0 - 2.5	0.0 - 2.5	35 - 40	110 - 115	871	792	41	0
Clare Roche - Director of Nursing (From 7th March 2022)	0.0 - 2.5	0.0 - 2.5	45 - 50	115 - 120	974	890	41	0
Jamie Marchant - Director of Primary, Community Care and Mental Health Services (To 1st December 2021); Director of Environment (From 1st December 2021)	0.0 - 2.5	(2.5) - (5.0)	30 - 35	45 - 50	584	556	-3	0
James Quance - Board Secretary (From 4th January 2022 to 31st December 2022)	0.0 - 2.5	0	5 - 10	0	111	85	9	0
Stephen Powell - Interim Director of Planning and Performance (from 1st April 2022)								
Debra Lawson Wood - Interim Director of Workforce and OD (from October 2022)	0.0 - 2.5	0	10 - 15	0	208	171	10	0
Mererid Bowley - Director of Public Health (from 27th June 2022)	2.5 - 5.0	0.0 - 2.5	40 - 45	70 - 75	763	673	46	0
Helen Bushell - Director of Corporate Governance and Board Secretary (from 9th January 2023)	0.0 - 2.5	0	5 - 10	0	70	49	4	0

The above calculations are provided by the NHS Pensions Agency and are based on the standard pensionable age of 60.

For Directors marked * the member is over retirement age in existing scheme therefore a CETV calculation is not applicable

As Non officer members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff Numbers

Number of Employed Staff

As at 31 March 2023, the total number staff employed by the Health Board stood at **1,929.39 Whole Time Equivalents** (WTE). The table below provides the average WTE of staff employed by the Health Board in 2021/2022 and 2022/2023 broken down by staffing group. This excludes hosted services such as the Boards of Community Health Councils and Health and Care Research Wales.

Staff Group	2021/22	2022/23
Add Prof Scientific and Technic	72.80	75.63
Additional Clinical Services	382.59	395.76
Administrative and Clerical	504.93	529.41
Allied Health Professionals	133.54	134.59
Estates and Ancillary	175.05	173.91
Healthcare Scientists	4.58	5.86
Medical and Dental	33.56	29.97
Nursing and Midwifery Registered	564.42	552.99
Grand Total	**1,871.46**	**1898.13**

Overall, on average, the Health Board has seen an increase of **26.68 WTE** in the number of staff employed in 2022/2023 when compared to 2021/2022. Despite this success, recruiting to a number of clinical roles, in particular Registered Nurse and Medical roles, continues to be challenging. There is a decrease overall of 11.42 WTE in the number of Registered Nurse staff employed by the Health Board. Registered Nurse vacancy levels within the wards has increased, with an overall vacancy deficit (excluding absence) of **30%** at March 2022, increasing to **33%** as at March 2023. To mitigate this risk the Health Board has recruited 2 overseas nurses with a further 5 due to arrive in April 2023. The Health Board has also continued to develop the Aspiring Nurse programme, to grow our own internal pipeline to address the deficits.

Staffing Composition

As of 31 March 2023, the Health Board employed **2,369** substantive employees (excluding bank workers) which equated to **1,929.39 WTE.** The number (headcount) of female and male employees of the Health Board are as follows:

	Female	Male
Headcount	2,028	341
Percentage	86%	14%

Of this staffing composition, at 31 March 2023, the Executive Team consisted of 9 voting members of the Board (inclusive of the Chief Executive Officer). There was one additional Director and the Board Secretary (both non-voting members) who are members of the Executive Team and are included in the staffing composition below:

	Female	Male
Headcount	8	3
%	73%	27%

Sickness Absence Data

Information on sickness absence for 2021/2022 and 2022/2023 is provided within the table below:

Staff Group	2021/22	2022/23
WTE Days Lost Long Term	28,157.95	29,910.21
WTE Days Lost Short Term	11,158.48	13,291.37
Total Days Lost	39,316.43	43,201.58
Total Staff Years (avg WTE staff Absent)	107.72	118.36
Average Working Days Lost	16.38	18.24
Total Staff Employed in Period (Headcount)	2401	2369
Total Staff Employed in Period with no absence (Headcount)	1276	882
Percentage of Staff with no Sick Leave	**53%**	**37%**

The Health Board's overall rolling sickness absence rate for 2022/2023 is **5.83%**, compared to **5.76%** in 2021/2022. The overall increase in staff absence is reflective of the difficult and challenging time, as the Health Board continue to respond to the impacts of the COVID-19 pandemic.

Staff Policies

Powys Teaching Health Board has a policy framework in place which covers policies and procedures that apply to employees and workers engaged with the Health Board. All workforce related policies are actively monitored, developed, and agreed in partnership with our Trade Union colleagues. The Equality Impact Assessment policy is applied throughout the financial year for the development of policies and procedures.

- for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities;
- for continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- otherwise for the training, career development and promotion of disabled persons employed by the Health Board.

All staff policies include a requirement to undertake an analysis of the impact of the policy in respect of equality. In conjunction with this approach, the *all Wales Managing Attendance at Work Policy* and *Recruitment and Selection Policy* were utilised to ensure fair consideration was given to applications for employment made by a disabled person and for supporting their continued employment.

Other Employee Matters

Health and Safety 2023/2024

The Health and Safety (H&S) team workplan focuses on the priorities of the Health Board via the Health and Safety Group (HSG). This plan covers a wide range of important areas and is designed to assist in managing and prioritising the resources of the health and safety team and provide support to departments and directorates to develop and ensure the local management of health and safety matters.

Three policies have been reviewed, updated, and approved by the Health and Safety Group in year. These have been communicated through Powys Announcements and are "live" on the intranet. These policies are;

- Manual Handling Policy
- Violence and Aggression Policy
- Stress Management Policy

A fundamental role of the Health and Safety Group (HSG) is to monitor the review and learning from accidents and incidents. A summary report is provided at each meeting with details of incidents at departmental level. During 2022/2023 the format has changed to make use of outputs from the Datix system.

Discussion at HSG focuses on ensuring robust review at departmental level of the incidents ensuring appropriate closure and learning. Review of data output from Datix is also assisting in improving the quality of the data input. As the membership of the Group has matured, "near misses" are also being reported.

The Executive Committee agreed that these areas should be prioritised across all departments and that the subsequent audit program of 2022/2023 would concentrate on reviewing these risk assessments as well as any service specific tasks.

The modules were;

- driving for Work
- lone Working
- display Screen Equipment
- violence and Aggression
- manual Handling
- workplace Stress

As part of the programme, twenty teams across various departments in Support Services, Estates, Workforce and Organisation Development, Women and Childrens Service Group and Community Services Group were audited by the Health and Safety and good practice, areas for development were shared via the Health and Safety Group.

Training and education are essential to allow staff to be aware and manage health and safety issues. With relation to the specific areas of violence and aggression and manual handling training, the Health Board has two directly employed trainers.

Welsh Ambulance Service NHS Trust (WAST) Health and Safety function are working with the Health Board to provide sessions for IOSH accredited Leading Safely course. This will provide training for Executive Directors and Assistant/Deputy Directors as well as adding a new element of training developed by WAST relating to "behavioural approach" to Health and Safety.

Alongside this approach, the local Health and Safety Officers have been supporting training for the IOSH Working Safety as part of the Workforce Managers Programme and to date 87 staff have completed the course.

To support the ongoing local management and compliance for staff relating to manual handling, the work for 2022/2023 has included a specific focus on manual handling, involving the introduction and training of manual handling link workers as identified in a Health and Safety Executive (HSE) Notification of Contravention in 2019. A commitment was made to appoint link workers within departments with the initial focus on the wards. Whilst there were some challenges during the Covid-19 pandemic, work has been undertaken to review the nominated leads and complete any gaps. It is expected to have a full complement of people across specific departments by the end of March.

Powys Teaching Health Board recognises that when staff deal with any situation in which individuals, whether Child or Adult, are violent or intimidating toward them, it can be very difficult. Appropriate Training is provided in accordance with the "All Wales NHS Violence and Aggression Training Passport and Information Scheme."

Teams within the Health Board work with a very diverse group of patients, and as such it is appropriate that they receive personal safety training, full prevention, and management training for physical intervention techniques, whichever is appropriate for their role/s, as identified by the service departments. The Training Programme is designed to meet identified training needs based upon Risk Assessment for Staff Groups.

To strengthen the resources available to staff a new webpage has been constructed and is live on the intranet. This will be updated and continually evolve and contains advice and guidance on a number of health and safety subjects, along with easy-to-follow videos on risk assessment and lone working. All H&S template documents are available through the website and SharePoint.

Following the identification of a number of Hand Arm Vibration incidents which resulted in action being undertaken by the Health and Safety Executive (HSE) they have acknowledged that a great deal of progress has been made by PTHB and the Estates department since early 2020, in relation to compliance with the Control of Vibration at Work Regulations 2005.

Beyond the work to respond to the Improvement Notices, an additional range of actions were committed and completed by the Health Board. These included;

- undertake a full audit of all equipment that poses a vibration risk to Support Services employees;
- policy and process for the procurement and purchase of low vibratory work equipment;
- implement a regime of tool maintenance;

- information;
- ensure the risk of vibration exposure for task undertaken within Support Services are suitably risk assessed;
- vibration Monitoring - monitoring and reviewing exposure levels on a regular basis; and
- health surveillance- identify any support services staff that have been exposed to the use of vibrating tool to check and ensure they are not suffering from ill health effects from past exposure.

The Health and Safety Group continues to take forwards its agenda supported by relevant subgroups, namely Fire Safety Group and Security Oversight Group.

Future Work Programme

The HSG will be developing work plan priorities for 2023/2024.

Expenditure on Consultancy

As disclosed in note 3.3 (page 29) of its financial statements, the Health Board spent £0.557M on consultancy services during 2022-23 compared to £0.505M M in 2021-22.

Off Payroll Engagement

For all off-payroll engagements as of 31 March 2023, for more than £245 per day:

No. of existing engagements as of 31 March 2023	18
Of which, the number that have existed:	0
for less than one year at time of reporting.	1
for between one and two years at time of reporting.	5
for between two and three years at time of reporting.	1

for between three and four years at time of reporting.	3
for four or more years at time of reporting.	7

	Number
Number. of new engagements, between 1 April 2022 and 31 March 2023	2
Of which...	
No. assessed as caught by IR 35	0
No. assessed as not caught by IR 35	2
No. engaged directly (via PSC contracted to department) and are on the departmental payroll.	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0

Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

NOTE FOR FINAL REVIEW STAGE – consider how we reflect numbers above as generally less than 5 is deemed identifiable.

There have been no-off payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2022 and 31 March 2023.

Exit Packages and Severance Payments

This disclosure reports the number and value of exit packages taken by staff leaving in the year. This disclosure is required to strengthen accountability in the light of public and Parliamentary concern about the incidence and cost of these payments.

	2022-23	2022-23	2022-23	2022-23	2021-22
Exit packages cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	0	0	0	0
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	0	0	0	1

Redundancy and other departure costs if paid would have been paid in accordance with the provisions of the NHS Agenda for Change Terms and Conditions and NHS Voluntary Early Release Scheme (VERS). Exit costs in this note are accounted for in full in the year of departure on a cash basis

in this note as specified in EPN 380 Annex 13C. Should the Health Board have agreed early retirements, the additional costs would have been met by the Health Board and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension's scheme and are not included in the table.

PART C: SENEDD CYMRU/WELSH PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

This report contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long-term expenditure trends, and the audit certificate and report.

Regularity of Expenditure

At the time this report was compiled the Regularity of Expenditure was yet to be received, this aspect of the report will be included in due course.

Fees and Charges

At the time this report was compiled the Fees and Charges was yet to be received, this aspect of the report will be included in due course.

Remote Contingent Liabilities

At the time this report was compiled the Remote Contingent Liabilities was yet to be received, this aspect of the report will be included in due course.

Compliance with Cost Allocation and Charging Requirements

At the time this report was compiled the Compliance with Cost Allocation and Charging Requirements was yet to be received, this aspect of the report will be included in due course.

Report on the Audit and Financial Statements

At the time this report was compiled the Report on the Audit and Financial Statements was yet to be received, this aspect of the report will be included in due course.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.3

Audit, Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**Internal Audit Progress Report**
Approved and Presented by	**Director of Corporate Governance / Head of Internal Audit**
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee 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 report.
- **Approve** the removal of the highlighted audit from the 2022/23 plan.

Approval	Discussion	Information
X		X

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

EXECUTIVE SUMMARY:

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

The following audit report has been finalised since the March 23 meeting of the Committee:

- Temporary Staffing Unit (Reasonable Assurance)

The progress report also includes details of the proposed removal of one audit from the 2022/23 plan.

BACKGROUND AND ASSESSMENT:

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

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

The 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.

Powys Teaching Health Board

Internal Audit Progress Report

Audit, Risk & Assurance Committee
May 2023

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

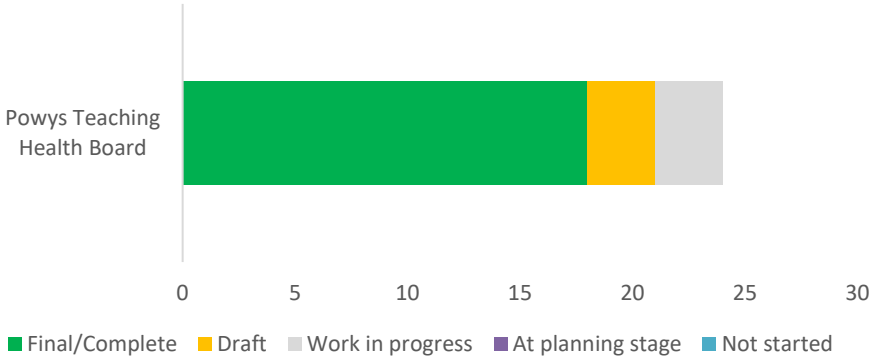
One assignment from the 2022/23 plan has been finalised since the previous meeting of the committee and is highlighted in the table below along with the allocated assurance ratings.

The full version of the report is included in the committee's papers as a separate item.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Temporary Staffing Unit	Reasonable	

3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 24 reviews included within the 2022/23 Internal Audit Plan (excluding the audit detailed under section 4 below), and overall progress at this stage of the year is summarised below.



From the illustration above it can be seen that eighteen audits have been finalised so far this year.

In addition, there are three audits that are at the draft report stage and three that are currently work in progress.

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. Changes to the 2022/23 Plan

Proposed removal of Planned Care / Recovery of backlog Services audit

The audit has been identified for removal from the 2022/23 plan due to the limited time and resources remaining for delivery. The Health Board has already received assurance around recovery through the 'Review of the Strategic Portfolio' work undertaken by Audit Wales.

5. Engagement

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

Board / Sub Committees

- Board Meeting – 29 March

Health Board Meetings

- Mark McIntyre, Deputy Director Workforce & OD – 15 March
- Hywel Pullen, Deputy Director of Finance – 3 April
- Helen Bushell, Director of Corporate Governance – 21 April
- Audit Wales – 30 March

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
Machynlleth Hospital Reconfiguration Project		*21*	*Environment*	*3*		*Final*	*Reasonable*	*January*
Looked After Children Health Assessments (Deferred from 21/22)		5	Nursing & Midwifery	2		Final	Substantial	January
Cancer Services - Access to Symptomatic FIT (Deferred from 21/22)		11	Medical	2		Final	Substantial	January
Welsh Language Standards		13	Therapies & Health Science	1		Final	Limited	January
North Powys Wellbeing Programme (Deferred from 21/22)		16	PC&MH	~~1~~	2	Final	Reasonable	January
Charitable Funds		8	Finance, Information & IT	2		Final	Reasonable	January

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Workforce Futures Strategic Framework (Deferred from 21/22)		4	Workforce & OD	3		Final	Reasonable	January
Women & Children's Services		18	PC&MH	~~1~~	2	Final	Substantial	January
Therapies and Health Sciences Professional Governance Structure		14	Therapies & Health Science	~~4~~	3	Final	Reasonable	March
Incident Management		6	Nursing & Midwifery	3		Final	Reasonable	March
Cyber Security		10	Finance, Information & IT	3		Final	Limited	March
Temporary Staffing Department		3	Workforce & OD	~~1~~	3	Final	Reasonable	May
Board Assurance Framework / Risk Management	Focus on development of effective assurance processes alongside risk identification / escalation.	1	Board Secretary	4		Draft	Reasonable	July
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		Draft	Reasonable	July
Occupational Health Follow-up	Follow-up of 21/22 Limited Assurance report to establish progress with implementation of agreed actions.	26	Workforce & OD	4		Draft	Reasonable	July
Savings Plans / Efficiency Framework	Development, monitoring and achievement of the Health Board's savings plans linked to recovery and the associated Efficiency Framework.	7	Finance, Information & IT	4		Work in Progress		July
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		Work in Progress		July

Planned output.	Outline Scope	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Internal Audit Recommendation Tracking Process	Review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	23	Board Secretary	4		Work in Progress		July
Reviews removed from the plan								
Covid 19 – Outbreak Control Plan, Contact Tracing	Use of WG contact tracing funding to allow health Staff to respond to Covid outbreaks.	25	Removal as no longer appropriate due to the changing Covid 19 situation. Agreed by March 23 ARAC					
Planned Care / Recovery of backlog Services	Provide assurance across key areas - Community Services / planned care / recovery of backlog services	17	Proposed for removal due to the limited time and resources remaining for delivery. The Health Board has already received assurance around recovery through the 'Review of the Strategic Portfolio' work undertaken by Audit Wales. To be agreed by May 23 ARAC					

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G 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
Machynlleth Hospital Reconfiguration Project	*Reasonable*	*Final*	*18/11/22*	*09/12/22*	*02/12/22*	*02/12/22*	*G*
Looked After Children Health Assessments	Substantial	Final	06/12/22	29/12/22	06/12/22	06/12/22	G
Cancer Services – Access to Symptomatic FIT	Substantial	Final	29/11/22	20/12/22	8/12/22	8/12/22	G
Welsh Language Standards	Limited	Final	21/10/22	11/11/22	12/12/22	16/12/22	R
North Powys Wellbeing Programme	Reasonable	Final	01/11/22	22/11/22	15/12/22	16/12/22	R
Charitable Funds	Reasonable	Final	29/11/22	20/12/22	20/12/22	20/12/22	G
Workforce Futures Strategic Framework	Reasonable	Final	06/12/22	29/12/22	17/01/23	18/01/23	R
Women and Children's Services	Substantial	Final	13/01/23	03/02/23	19/01/23	19/01/23	G
Therapies and Health Sciences Professional Governance Structure	Reasonable	Final	02/03/23	23/03/23	08/03/23	08/03/23	G
Incident Management	Reasonable	Final	23/02/23	16/03/23	07/03/23	09/03/23	G
Cyber Security	Limited	Final	08/02/23	03/03/23	03/03/23	09/03/23	G
Temporary Staffing Unit	Reasonable	Final	27/03/23	19/04/23	06/04/23	11/04/23	G

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	95% 20 from 21	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	83% 15 from 18	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 18 from 18	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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

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Temporary Staffing Unit
Final Internal Audit Report

April 2023

Powys Teaching Health Board

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

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

Contents

Review reference:	PTHB-2223-03
Report status:	Final
Fieldwork commencement:	10 January 2023
Fieldwork completion:	22 February 2023
Debrief meeting:	15 March 2023
Draft report issued:	10 March 2023 & 27 March 2023
Management response received:	6 April 2023
Final report issued:	11 April 2023
Auditors:	Liz Vincent, Principal Auditor Ian Virgill, Head of Internal Audit
Executive sign-off:	Deborah Wood-Lawson, Director of Workforce and OD
Distribution:	Mark McIntyre, Deputy Director Workforce & OD Eleanor Davies, Human Resources Business Partner
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

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

Executive Summary

Purpose

The overall objective of the audit was to review and evaluate the adequacy of the systems and controls in place within the Temporary Staffing Unit.

Overview

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

- Develop a structured approach to engagement with service users to identify and address areas of improvement in service provision.
- Recruitment process and the length of time it takes to complete the Pre-employment checks.
- Errors in the rate of pay for off contract agency invoices, and the recording of the invoice date within Oracle.
- Bank and Agency Reports not produced on a regular basis and the level of scrutiny of these reports is unclear.

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

Report Opinion

		Trend
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	Policy and Procedures	Substantial
2	TSU structure and operating effectively	Limited
3	Justification, authorisation and paid at the correct rate	Reasonable
4	Reporting and Monitoring	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	Effective engagement with service users	2	Design	Medium
2	Recruitment Process	2	Design	High
3	Processing Agency Invoices	3	Operation	Medium
4	TSU Bank and Agency Reports	4	Operation	Medium

1. Introduction

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

1.2 Services within the Health Board may from time-to-time experience staffing difficulties. In order to maintain service provision, ensure the safety of patients/service users and staff and comply with staffing legislation, there will be a need to secure temporary staffing.

1.3 The Temporary Staffing Unit (TSU) is responsible for the sourcing and allocation of bank and agency workers across all staffing groups within the organisation.

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

- Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment or supply of bank and agency staff
- Financial loss due to unnecessary usage or incorrect payment of bank and agency staff
- Issues relating to bank and agency usage are not identified or addressed

2. Detailed Audit Findings

Objective 1: Appropriate and up to date policy, procedures and guidance are in place to efficiently and effectively direct the operation of the Temporary Staffing Unit and the use of bank and agency staff.

2.1 A Bank Staff Management and Operating Procedure is in place that sets out the high-level controls in relation to the engagement and payment of bank and agency staff. The procedure also outlines how the Health Board ensures that there are robust and appropriate standards in place in respect of the use of Bank Workers.

2.2 There is a Bank and Agency Policy, and several other procedures to support the use of the Bank Staff booking system and to assist with the recruitment process and administering invoices for payment. The policy includes a number of flowcharts. The Pre-approval flow chart (Appendix A), describes the various options of the levels of cover that should be considered before hiring bank and agency. The Temporary Staffing Booking Process Flowchart (Appendix B) details the process that must be followed when there is no alternative but to use temporary staffing.

2.3 The policy and procedure are both aligned and include all relevant information, in a clear and concise way. Both include key objectives to ensure that there is a consistent and safe approach in the management of bank staff across the organisation. We can confirm that these documents are published on the Health Board's SharePoint site and are readily available to the relevant staff.

Conclusion:

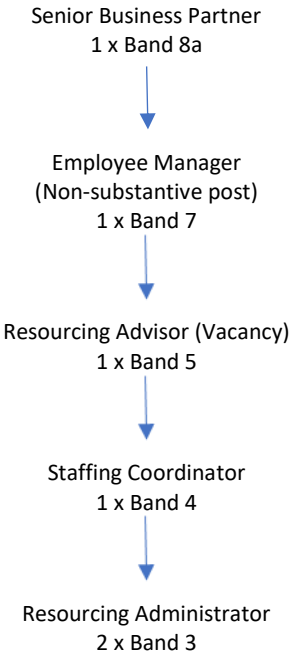
2.4 The Health Board has an up to date, clear and concise policy and procedure in place for the management of bank staff across the organisation. We have provided Substantial Assurance in relation to this objective.

Objective 2: The Temporary Staffing Unit is adequately structured and operating effectively to enable the robust and timely sourcing and allocation of bank and agency staff.

2.5 The establishment of the TSU department was restructured in September 2021. Since then, the department has lost two key members of staff and has also experienced long term sickness over the last six months. This had a significant impact on the department and the services that they provided.

2.6 To address the shortfalls, in 2021 a band 3 post was taken from another area in Workforce and Organisational Development (WOD) to assist TSU. In addition, in August 2022 a Band 7 management post transferred from the HR Business Partner team to help support the department. This role oversees and manages the WOD admin, TSU and E-systems. This is temporary solution which has left a gap in another part of the directorate. At the time of the audit, we were informed that another experienced member of the team will be leaving, and the Band 5 Resourcing Advisor post will be vacant as from 6th March 2023.

2.7 The current TSU staffing structure is as follows:



2.8 The two Band 3 Resourcing Administrators and one Band 4 Staffing Coordinator are responsible for the recruitment of Bank Staff, allocating and resourcing of shifts, and processing of agency invoices for payment. They also process annual leave payments for payroll, timesheets for shadow shifts, retire and returns and locum requests and invoicing for locum.

2.9 The recruitment of Bank and shift cover needs to be actioned daily, whereas the role of invoicing was historically completed every 2-3 days. Due to the number of agency staff that the Health Board are currently using, the department had to increase the role of invoicing to each day. Between March 2019 and February 2020, TSU processed 5,530 invoices, whereas in March 2022 to February 2023 they processed 9,622. This shows the increase of work that the team has had to manage, and consequently has impacted on the recruitment process. The department had to prioritise the workload within the existing establishment.

2.10 The department are also utilising and training up admin staff that work for WOD so that they can assist with the current pressures due to the increased numbers in agency cover.

2.11 To support with the recruitment of bank staff the department has TRAC user guides in place to assist with each stage of the recruitment process. To support with allocating of shifts Allocate desktop procedures are also available to guide them.

2.12 We contacted 13 different staff members across the Health Board who regularly utilise the TSU to ascertain if they felt that the TSU provided them with a good service and if the unit is meeting the needs of the Health Board. Eight provided feedback and all felt that the department was under resourced, which was impacting on the services that they provide. The respondents also highlighted issues with the length of time it takes for the pre-employment checks to be completed, the response time to emails and not answering telephone calls. **(Matter Arising 1)**

2.13 The TSU ensure that there is a constant advert out for Bank Staff. In January, the department created adverts for each location, instead of a generic advert that covered the whole Health Board. It is hoped that this will help to identify and address the areas in which they are struggling to appoint to.

2.14 A report identifying all shifts that were allocated to bank and agency for November 2022 was obtained from the Bank Staff booking system. 851 shifts in total were allocated in November; 456 shifts (54%) were Bank, and 395 shifts (46%) were Agency. 144 (36%) of the Agency shifts were off contract and awarded to Thornbury.

2.15 There has been an 81% increase in the number of shift requests when you compare the same period in 2019 to 2022. The table below shows a decrease in the number of shifts that have been filled by bank, but a 66% increase in agency filled shifts, especially for off contract agency. As highlighted in 2.9 this generates more work for TSU, particularly when processing invoices for payment.

Month	Shift Requests	Filled by Bank	Filled by Agency (on contract)	Filled by Agency (off contract)	Unfilled	Re-Called
November'19	2,326	1,368	349	186		349
November'22	2,867	1,279	567	247	325	449

2.16 All pre-employment checks are automatically sent out at the time of 'offer' through the TRAC systems. TSU have informed us that most delays in the pre-employment checks take place when trying to obtain Occupational Health forms, References and DBS checks. Unfortunately, these referrals are with the candidate and not the department, however the team do follow up this information.

2.17 A tracker spreadsheet was recently implemented to help with monitor each new starter. In addition to this, TRAC produces a weekly 'Management update' report that provides the same information, which is reconciled to the tracker spreadsheet each week. We compared the job reference numbers on the Tracker to the Management update report and found discrepancies between them both. **(Matter Arising 2)**

2.18 Testing was carried out using the 'Management update' report data to establish if individuals are added onto the Bank in a timely fashion. 93 people were identified on the report, and we identified several delays in each of the stages of the process. **(Matter Arising 3)**

Conclusion:

2.19 Changes in key members of staff and the increase in the number of agency staff that the Health Board are using is impacting on the services that TSU provide. Feedback provided by the users of the service identified that they felt that improvements could be made with the service provided. We have provided Limited Assurance in relation to this objective.

Objective 3: All requests for bank and agency staff are supported by appropriate justification and authorisation, and all completed shifts are appropriately verified and authorised prior to payment at the correct rate.

2.20 A sample of 30 shifts that were allocated to bank and agency for November 2022 were selected for testing: 16 Bank and 14 Agency

2.21 The justification for the cover is identified in Health Roster, which is uploaded into the Bank Staff booking system. Each shift within our sample had a valid reason for requesting the cover, of which 22 out of 30 (73%) related to vacancies.

2.22 Community Service Managers meet with the TSU department weekly and during these meetings verbal authorisation is provided. The initial of approver is entered in the Banks Staff booking system by TSU. Email trails approving shifts that are

known in advance are sent to the generic TSU email. Shifts that are short notice that require urgent cover are approved verbally. For our selected sample of agency staff, we were unable to trace the authorising emails. This was due to the way in which the email trails are stored within the generic email address. (**Matter Arising 4)**

2.23 Time sheets for Agency staff are authorised by the Ward Managers, whereas Bank Staff are now paid via Health Roster. This has been in place since November 2022.

2.24 Testing was carried out to establish if bank and agency staff had been paid at the correct rate and within a timely fashion. Bank staff rate of pay is automatically calculated via Health Roster. There is an agreed hourly rate of pay for on contract and off contract agency cover. We reviewed a number of invoices and found discrepancies with the hourly rate of pay for off contract invoices. We also found instances of invoices being paid later than 30 days from the date of invoice. (**Matter Arising 5**)

Conclusion:

2.25 Requests for Bank and agency staff are supported by appropriate justification and authorisation. We found discrepancies with the rate of pay for off contract invoices and noted that some invoices had been paid later than 30 days. We have provided Reasonable Assurance in relation to this objective.

Objective 4: Accurate and timely reports on bank and agency usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required

2.26 Weekly bank and agency usage reports are produced by the TSU department for the Head of Nursing. These are used to identify which agencies are being used and to understand supply and demand. It was identified that these reports have not been issued to the Heads of Nursing since late November 2022. **(Matter Arising 6)**

2.27 A bank and Agency usage report is issued and sent to NWSSP Procurement Sourcing department each month. Other Health Boards also provide the same data, which is collectively discussed at the Temporary Staffing Workforce Group. The report allows them to review the number of WTE Agency staff that have been used by month, which is broken down by On or Off Contact.

2.28 Establishment reports are produced each month for Nursing, AHP and for the Environment Directorate. These reports are predominately discussed at the monthly Senior Management Team (SMT) for Therapies and the Environment Directorate.

2.29 We were informed that establishment reviews are scheduled Bi-annually. The reviews look at whole establishment information such as budgeted establishments, staff in post, vacancies and bank and agency usage. These reviews are conducted

by the Director of Nursing and Midwifery, Deputy Director of Nursing and Midwifery, Head of Nursing and Lead Nurse for Informatics and Nurse Staffing.

2.30 We were unable to determine if the Nursing Establishment Report was scrutinised at any groups or committees within Community Services. It was also difficult to establish if the report was disseminated to the appropriate people as only Finance and WOD management are on the distribution list for when the reports are sent out. **(Matter Arising 6)**

2.31 Finance have confirmed that whilst all budget holders have direct access to the Qlik online finance tool to understand costs in detail, Finance also send senior leads high-level dashboards that includes a chart and table that tracks agency spend.

2.32 A comprehensive performance report on Workforce Performance is also discussed at the Workforce and Culture Committee, which includes an analysis of variable pay.

Conclusion:

2.33 TSU and WOD produced appropriate reports on Bank and Agency Usage. Although we could evidence them being developed and issued, the regularity and distribution to appropriate staff and groups / committees could be improved. We have provided Reasonable Assurance in relation to this objective.

Appendix A: Management Action Plan

Matter Arising 1: Effective engagement with service users (Design)	**Impact**
Whilst we note that the TSU meet regularly with departmental managers, there is currently no structured approach to engagement with users to ascertain if the Nurse Bank is meeting the needs of the services and therefore operating effectively. Similarly, we found that no satisfaction surveys are being undertaken with Bank staff. We contacted a sample of 13 staff members who work across the organisation to ascertain if they felt that the TSU provided them with a good service, and if the unit is meeting the needs of the Health Board. Eight provided feedback and all felt that the department was under extreme pressure, which was impacting on the services that they provide. The users also identified a number of specific areas where they felt the service provided by the TSU could be improved. The full detail of this feedback can been shared with the TSU.	Potential risk of: • Issues relating to the Temporary Staffing Unit are not identified or addressed.

Recommendations		**Priority**
1	The TSU's approach to engagement with service users, including ward management and bank staff requires a review, to ensure the team are continually striving to meet the needs of the Health Board, informed by service users.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Implement a structured programme of engagement with regular users of the TSU service in addition to the 3 times a week staffing huddles. Set up Yammer for engagement with staff.	Qtr. 1 23/24	Eleanor Davies, Human Resources Business Partner

Matter Arising 2: PEC Tracker (Operation)			**Impact**
TSU maintain a tracker spreadsheet for each new starter, to monitor the pre-employment checks (PEC). TRAC also produces a weekly 'Management update' report that provides the same information which is currently being reconciled to the tracker spreadsheet each week by TSU staff. We compared the job reference numbers that were shown on the TRAC update to the TSU Tracker and we found discrepancies between both. There were seven job reference numbers on TRAC that were not shown on the TSU Tracker, and conversely there were two job references on the TSU Tracker that were not on TRAC. The current process of cross referencing the report to the tracker spreadsheet is a duplication of work and not the most efficient way to monitor the PEC.			Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment or supply of bank and agency staff
Recommendations			**Priority**
2	Management need to consider utilising the TRAC Management Update Report to monitor the PEC stages. The data is more accurate, it is a more efficient process and will help to reduce discrepancies.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	Trac report to be run on a Monday morning each week and used to update the TSU Recruitment Tracker for monitoring and corrective action.	Qtr. 1 23/24	Eleanor Davies, Human Resources Business Partner

Matter Arising 3: Recruitment process (Operation)	**Impact**

Testing was carried out using the Management Update Report that was produced on 16 January 2023 to establish if individuals are added onto the Bank in a timely fashion.

93 people were identified, and all were at different stages in the process, as detailed in the following table:

Stages	**Meaning**	**Number**
Authorisation	Once the advert has been authorised by requester i.e., Ward Manager, TSU will vet the details and will send links to ESR and NHS Jobs	1
Shortlisting	TSU are responsible for this stage	9
Long Listing	Jobs that are out to advert that need to be moved to outcome and closed on TRAC	7
Interview	Shortlisted by TSU and sent back to requester to arrange an interview date with candidate	5
Offer	Those who have been offered the position - Offer letter and pre-employment checks are needed	71
	TOTAL	93

71 people were in the 'Offer' stage of the process, they are either in the 'Conditional Offer' application stage waiting for their PEC's to be completed, or the 'Checks ok' or 'Outcome recruited' stage meaning that the PEC's have been finalised within TRAC.

53 out of 71 people were in the 'Conditional Offer' stage. The Health Board has introduced a KPI (KPI T13) which looks at the date that the vacancy was created to when the individual was given a conditional offer. The turnaround should be within 44 days.

- 33 out of 53 exceed the 44-day target, of which 6 were greater than 100 days, 4 at 168 days.
- The average number of days from the creation of the vacancy to the conditional offer is 51 days

Impact

Potential risk of:

- Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment or supply of bank and agency staff

- All 53 candidates do not have completed PEC - no dates identified within TRAC
- 17 had their conditional offer made during the period April - November 2022, as follows:

Month	Number
April	1
May	7
August	1
September	4
October	2
November	2
Total	17

16 people have been identified as 'Checks OK' or 'Outcome Recruited'.

- 15 out of 16 have a date identified within TRAC to show that all checks have been completed.
- 7 out of 16 have been categorised as 'Checks Ok', which should move to 'outcome' stage. This will indicate to the enablement team that they can produce the new appointment form. Two out of the seven, the date the checks were completed was in March and June 2022.
- The average number of days between the date the offer was made and the date that all PEC's were completed was 76.
- Target to complete PEC's is 25 days, of which 12 out of 15 exceeded this timeframe as follows:

26 - 50 days	2
51 - 100 days	5
101 - 150 days	2
151 - 164 days	3
TOTAL	12

Recommendations		Priority
3	Management need to review the current bank staff recruitment process to identify the issues that are causing delays. Appropriate actions then need to be implemented to address the issues and allow for improved compliance with the KPI's.	**High**

Agreed Management Action		Target Date	Responsible Officer
3	Weekly internal recruitment meetings to be held with members of the TSU to review and analyse the TSU Recruitment Tracker report to monitor performance and take corrective action for areas causing delays. KPI report to be produced and monitored weekly to monitor compliance.	Qtr. 1 23/24	Eleanor Davies, Human Resources Business Partner

Matter Arising 4: Locating authorising email trails (Design)			**Impact**
We were unable to determine if the agency shifts for our selected sample were known in advance and would therefore warrant an authorising email or were short notice and therefore would only be supported by verbal approval. We therefore attempted to locate an approving email for all agency shifts within our sample but found no results. What was apparent during this process, however, was the way in which the email trails were stored within TSU's generic email address. There was no identifiable reference in the email header, such as request ID number or the date of the shift therefore making any authorising email difficult to track down.			Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment or supply of bank and agency staff
Recommendations			**Priority**
4	Management need to agree on an identifiable reference for storing approving emails. This will improve the process of locating the email trails within the generic email address.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	Unique reference to be included within the subject box for all email shift requests for on and off contract agencies. On and off contract agency approval at 3 times a week Staffing Huddles with CSMs will be confirmed in an email.	Qtr. 1 23/24	Eleanor Davies, Human Resources Business Partner

Matter Arising 5: Processing Agency invoices (Operation)	**Impact**
All agency invoices, including timesheets are sent to finance via a generic email address, that both TSU and Finance have access to. Finance adds the received invoices to an 'Agency spreadsheet' and send to TSU to check and approve for payment. TSU check the details shown on the spreadsheet to the Bank Staff system, such as the hours worked and the dates of shift and enter the date of approval onto the spreadsheet. At the time of checking the TSU will add the invoice number to the Bank Staff system so that there is an audit trail of the invoice numbers. This is sent back to Finance to upload into Oracle to process for payment. Testing was carried out on 14 agency invoices to ensure that they had been paid at the correct rate and within a timely fashion. The following issues were identified: • For 2 out of 14 we could not locate the invoice number within the Bank Staff system. One shift was worked on 01/11/22 and the second was 22/11/22, both for different people and agencies; • For 7 out of 12 the recorded invoice number in the Bank Staff System did not correspond to the invoice number shown on the agency spreadsheet; • For 4 out of 12 the rate of pay was different to the agreed contact price; and • the invoice date recorded in Oracle is not the actual invoice date for any of the invoices reviewed. Using the actual invoice date and not the date recorded in Oracle meant that 3 out of 14 invoices were not paid within 30 days.	Potential risk of: • Financial loss due to unnecessary usage or incorrect payment of bank and agency staff

Recommendations		**Priority**
5.1	Management need to ensure that the invoice numbers and dates are accurately recorded in all systems, and correspond to the actual invoice.	**Medium**
5.2	Management need to ensure that the rate of pay is correct before authorising the invoice for payment.	

Agreed Management Action		Target Date	Responsible Officer
5.1 & 5.2	The standard operating procedure for invoicing will be reviewed to ensure that both the TSU and Finance are clear of their responsibilities in the process. This will include checks on invoice numbers, dates are accurately recorded and rates of pay are correct.	Qtr.1 23/24	Eleanor Davies, Human Resources Business Partner / Christian Thomas, Assistant Director of Finance
	A new self-billing process is being implemented for on-contract Agencies which will remove a number of the current manual checks required for invoice payments, improving accuracy.	Qtr.2 23/24	Eleanor Davies, Human Resources Business Partner / Christian Thomas, Assistant Director of Finance

Matter Arising 6: TSU Bank and Agency Reports (Operation)	**Impact**
Weekly bank and agency usage reports are produced by the TSU department for the Head of Nursing. These are used to identify which agencies are being used and to understand supply and demand. They are also used for monitoring block bookings and securing registered nurses for the safety and governance of patient care. The volume of additional staff required for enhanced levels of care is also captured, as well as the cost of the agencies that are being used. It was noted that these reports have not been issued to the Head of Nursing since late November 2022. Routine bank and agency usage reports are not issued to Facilities or Therapies department. TSU however do meet with Facilities on a monthly basis to discuss staffing issues, whereas monthly meetings with Therapies needs to be established. We were unable to confirm if the monthly Nursing Establishment Report was scrutinised at any groups or committees within Community Services. Unlike Therapies and the Environmental Directorate not all areas within Community Services have SMT meetings in place. It was also difficult to establish who received this report. Neither the Head of Nursing, Community Service Group Managers or Senior Managers for Unscheduled Care and Planned Care are on the distribution list for when the report is sent out.	Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment or supply of bank and agency staff

Recommendations		**Priority**
6.1	Management should ensure that accurate and timely reports on bank and agency usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Dashboards to be produced for nursing wards, Mental Health, facilities, AHP. These dashboards will show the bank and agency usage/costs, fill rate.	By the end of Qtr. 1 23/24	Eleanor Davies, Human Resources Business Partner

Patterson, Liz 12/05/2023 15:46:31

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.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.1

Audit, Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**Draft Head of Internal Audit Opinion & Annual Report 2022/2023**
Approved and Presented by:	**Director of Corporate Governance / Head of Internal Audit**
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To provide the Audit, Risk and Assurance Committee with information regarding the draft Head of Internal Audit Opinion for 2022/23 and the draft Annual Report.

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- **Consider and note** the Draft Head of Internal Audit Opinion and Annual Report for 2022/23**.**

Approval	Discussion	Information
	X	X

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

EXECUTIVE SUMMARY:

The draft HIA Opinion for 22/23 is that 'The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively'.

From the individual audits completed at the time of producing the draft Annual Report, the following final / draft ratings have been provided:

- 4 Substantial Assurance
- 12 Reasonable Assurance
- 3 Limited Assurance.
- 2 advisory or non-opinion

The Report also includes details of the 2 audits that have been removed from the plan during 2022/23, as reported to previous meetings of the Committee. These audits and the reason for their removal / deferment have been considered when compiling the draft HIA Opinion.

The draft Annual Report includes a number of highlighted areas where reference is made to reports that were in draft and audits that were work in progress (WIP) at the time of writing. These will be updated to reflect the position when the final HIA Opinion and Annual Report are produced.

The HIA Opinion will need to be reflected within the Health Board's Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the 3 Limited Assurance opinions issued during the year and the significance of the recommendations made.

BACKGROUND AND ASSESSMENT:

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

This is achieved through delivery of the annual audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2022/23 plan was formally approved by the Audit Committee at its March 22 meeting.

The draft Annual Report sets out the draft HIA Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

The report also details the outcome of audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for the Health Board.

NEXT STEPS:

The final Head of Internal Audit Opinion and Annual Report will be submitted to the Committee and Board in July.

Head of Internal Audit Opinion & Annual Report 2022/2023

May 2023

Powys Teaching Health Board

Contents

Report status:	Draft
Draft report issued:	04 May 2023
Final report issued:	
Author:	Ian Virgill, Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit Committee:	May 2022

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Powys Teaching Health Board's (The 'Health Board') Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

Our internal audit plan is agile and responsive to ensure that key developing risks to the Health Board are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an

overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for the 2022/23 year was initially presented to the Committee in March 2022. Changes to the plan have been made during the course of the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) (in March 2023), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards for 2022/23. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2022/23

Substantial Assurance	Reasonable Assurance
• Control of Contractors: Follow-up • Looked After Children Health Assessments • Cancer Services - Access to Symptomatic FIT • Women & Children's Services	• Staff Rostering • Security Services • Machynlleth Hospital Reconfiguration Project • North Powys Wellbeing Programme • Charitable Funds • Workforce Futures Strategic Framework • Incident Management • Therapies and Health Sciences Professional Governance Structure • Temporary Staffing Department • Risk Management and Board Assurance Framework (Draft) • Performance Management & Reporting (Draft) • Occupational Health Follow-up (Draft)
Limited Assurance	**Advisory & Non-Opinion**
• IT Infrastructure and Asset Management • Welsh Language Standards • Cyber Security	• Site Leadership & Coordination • Decarbonisation
No Assurance	**Assurance yet to be determined**
N/A	• Savings Plans / Efficiency Framework (WiP) • Follow-up Action Tracker (WiP) • SLAs for IN-reach Medical Staff (WiP)

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Powys Teaching Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the

Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2022/23 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were three audits in 2022/23).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23 and reported to the Audit and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.

- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, five were allocated Substantial Assurance, twelve were allocated Reasonable Assurance and three were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. In addition, two advisory or non-opinion reports were also issued.

At the time of producing the draft Annual Report, two audits are still work in progress with the assurance rating yet to be confirmed. It is anticipated that the majority of the work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the 8 areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken four reviews in this area.

Welsh Language Standards – At the time of the audit, the Health Board needed to develop and publish a formal Welsh Language Policy. There was also a need to undertake a full review of the action plans for achieving compliance with the standards that were produced in 2019 to ensure they were appropriate and applicable to the relevant service areas. The arrangements for monitoring and reporting progress against the action plans needed to be reviewed and strengthened and regular meetings established between the Welsh Language department and service leads. We issued a **limited** assurance opinion.

Risk Management and Board Assurance Framework (Draft) - Work is progressing to develop the Health Board's BAF but it is not yet finalised or operational. A comprehensive and up to date Risk Management Framework and toolkit is in place but risk management training has not been undertaken during the year. Effective processes are in place for recording, monitoring and escalating risks at Corporate and Service levels. However, the role of the Audit Committee and Corporate Risk and Assurance Group need to be confirmed. We issued a draft **reasonable** assurance opinion.

Internal Audit Recommendation Tracking Process *[WiP]*

A review of the draft Annual Governance Statement highlighted that it was generally consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents. *– Still to be confirmed by review of the draft AGS submitted to the May AC.*

Strategic Planning, Performance Management & Reporting

We have undertaken two reviews in this area.

North Powys Wellbeing Programme – Appropriate approvals were in place for the Programme at the Programme Business Case and Strategic Outline Case stages, along with the required funding. A plan had been in place for 21/22 but there was a need to finalise the 22/23 programme plan to ensure effective on-going management, monitoring and reporting of the programme. We also identified the need to ensure standardised processes were in place for monitoring the acceleration for change projects, carry out effective on-going review and management of the programme risk register and ensure the benefits and outcome framework and service mapping were effectively updated. We issued a **reasonable** assurance opinion.

Performance Management & Reporting (Draft) - There are robust processes in place for the production of the Integrated Performance Report which are working effectively. There is a schedule in place to ensure that the Integrated Performance Report is completed in time for the relevant governance forums and effective validation processes are in operation.

Further work is however required to ensure the Integrated Performance Framework is fully implemented. We issued a draft **reasonable** assurance opinion.

Financial Governance and Management

We have undertaken two reviews in this area.

Charitable Funds – The Health Board's Charitable Funds policy was overdue for review. The processes for managing donations and expenditure are operating effectively although enhancements were required for recording donations relating to a single event and the completion of application forms for expenditure. Regular reports needed to be issued to each fundholder and discussed with them and the Charitable Funds Committee Terms of Reference were due for review. We issued a **reasonable** assurance opinion.

Savings Plans / Efficiency Framework (WiP)

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The four primary care contractor payment systems were given either Reasonable or Substantial Assurance, with the audits of Payroll and Accounts Payable both receiving Reasonable Assurance.

Quality & Safety

We have undertaken three reviews in this area.

Looked After Children Health Assessments – The Looked after Children (LAC) Team have developed comprehensive procedures and have robust processes in place which are working effectively and adhere to the best practice standards set out within "The Framework". The LAC Team take a pro-active approach to the Health Assessment process, and we could evidence that they work above and beyond their roles and responsibility to ensure that looked after children receive a Health Assessment as soon as they become looked after. We issued a **substantial** assurance opinion.

Cancer Services - Access to Symptomatic FIT – There are effective governance arrangements in place for the Cancer Renewal Programme, which includes improving access to FIT as one of its key pathways. Access to FIT is in place for all Powys residents and supporting guidance and training has been made available to all GP practices. There was a need to ensure that a breakdown of FIT figures is received from the Wye Valley Trust. We issued a **substantial** assurance opinion.

Incident Management – The Health Board has Incident Management guidance in place but needed to publish a Health Board wide Incident Reporting procedural guidance and develop a navigable incident reporting page on SharePoint. Key stages / processes within the incident reporting cycle were not always undertaken within expected timelines. There was

also a lack of evidence of periodic reporting / monitoring of incidents within the Community Services Group. We issued a **reasonable** assurance opinion.

The planned advisory work on the Covid 19 – Outbreak Control Plan, Contact Tracing was removed from the plan as it was no longer appropriate due to the changing Covid 19 situation.

Information Governance & Security

We have undertaken two reviews in this area.

IT Infrastructure and Asset Management - Although improvements in monitoring and updating equipment have taken place, the infrastructure still contains old items and is subject to security and resilience weaknesses. We identified the following issues; old equipment was in place which results in a security risk, there was limited active monitoring and management of the infrastructure, Switches were not patched, server rooms had weakness which resulted in reduced resilience, poor cabling resulted in unmanaged hubs being deployed and the network architecture was flat and without firewall provision. We issued a **limited** assurance opinion.

Cyber Security – A cyber security improvement plan has been developed, and we noted progress in improving the overall security of the organisation. However, the reporting of the progress had ceased and there was limited detail on actions, and no reporting of the security position of the Health Board. We also noted weakness in the security and validity of back up information. There was a lack of detail in cyber security position reporting, asset location and cyber security condition information was incomplete and inaccurate and backup storage was not secure and there was no record of test restorations being carried out. We issued a **limited** assurance opinion.

The two reviews undertaken within the Information Governance and Security area both received limited assurance ratings. The Health Board will need to ensure that going forward there is appropriate investment and development within this area to address the identified issues.

Operational Service and Functional Management

We have undertaken five reviews in this area.

Site Leadership and Coordination – The advisory review identified that the Health Board had approved an appropriate site coordination and leadership model which was being effectively implemented, supported by robust governance arrangements. We proposed opportunities for consideration by the Health Board including; reviewing the role of site co-ordinators, holding joint 'local' meetings for some sites and enhancements to the site co-ordination forum.

Security Services – Appropriate security structures and groups are in place within the Health Board, but improvements are required in areas such as attendance, record keeping and updates to the Health & Safety Group.

Documented security plans were not in place for all service areas. Where plans were in place, they were not being reviewed centrally. We issued a **reasonable** assurance opinion

Women & Children's Services - Effective governance structures are in place within the Women and Children's Service, supported by robust risk management and financial management arrangements. The workforce and risk management controls within the School Nursing and Health Visiting Departments are also well established and operating effectively. We issued a **substantial** assurance opinion.

Therapies and Health Sciences Professional Governance Structure - The Directorate has structures in place which allow for scientific and therapy staff, professional registrants and practitioners to work within clearly defined professional and clinical governance arrangements. The Policies and procedures required review and finalisation and there was no overarching Framework in place. The process for identification of any professionally registered Therapy and Health Science professionals who are not operationally managed by the Professional Heads of Service also required strengthening. We issued a **reasonable** assurance opinion.

Workforce Management

We have undertaken five reviews in this area.

Staff Rostering – Policies and procedures are in place, and formal HealthRoster training has been delivered to all roster creators and Clinical Services Managers. However, a significant number of rosters were not being produced, approved, and published by wards / teams in a timely manner and in line with the Staff Rostering Policy. Rosters are produced in accordance with funded establishments and ensure appropriate skill mix. The HealthRoster system had several functionalities that were not being exploited to their full potential. We issued a **reasonable** assurance opinion

Workforce Futures Strategic Framework – Effective partnership and governance arrangements are in place for the Framework and regular reporting is taking place within the Health Board. However, management need to ensure annual, or more frequent, updates are provided on the outcomes. The action plans for the Workforce Futures Framework Programme Board and Workforce Futures Oversight Group could not always be followed from one meeting to the next. We issued a **reasonable** assurance opinion

Temporary Staffing Department - The Health Board has policy and procedure in place for the management of bank staff across the organisation. A structured approach to engagement with service users needed to be developed to identify and address areas of improvement in service provision. We identified further issues around the recruitment process and the length of time to complete Pre-employment checks, errors in the rate of pay for off contract agency invoices, the consistent recording

of the invoice date within Oracle. We issued a **reasonable** assurance opinion.

Occupational Health Follow-up [draft] - Good progress has been made in addressing the recommendations from the 21/22 limited assurance report. Two of the six actions had been fully complete with the remaining four partially complete. We issued a Reasonable assurance opinion. We issued a draft **reasonable** assurance opinion

SLAs for In-reach Medical Staff (WiP) -

Capital & Estates Management

We have undertaken three reviews / outputs in this area.

Control of Contractors: Follow-up - Agreed actions from the prior review had been largely implemented, with 6 of the 7 recommendations closed (including 3 high priority matters). Only one matter remained partially outstanding, in relation to site-specific signing in protocols. Recognising the controls already implemented by the Estates team, the recommendation priority was lowered from high to medium; with the remaining actions, due to their nature, to be undertaken in conjunction with the wider Health Board. We issued a **substantial** assurance opinion.

Decarbonisation – This was an advisory review which identified specific opportunities for the Health Board but also affirmed common themes to provide an overview of the overarching position across NHS Wales. Our report concluded that, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. Our recommendations aimed to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

Machynlleth Hospital Reconfiguration Project - The project operated within a robust governance framework during the period, with reasonable controls evidenced in areas including valuation and payments. Initial preparations for commencing the commissioning and handover stages were also evidenced. The forecast outturn cost remained within budget, and whilst noting the project was delayed by a total of 13 weeks from the original contractual completion date, risks to operational delivery are considered minimal. The key matters arising at the project were; the need for consistent inclusion of the cost report within Project Board papers and the need for a project-specific scheme of delegation, to ensure compliance with Standing Orders. We issued a **reasonable** assurance opinion.

Advice and support were also provided to the Health Board through the year in relation to the future development of integrated audit plans.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider

progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

It is the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

From the specific follow up audits undertaken in 2022/23, it was identified that progress had been made by management in implementing recommendations from the following previous Limited Assurance audits, with improved assurance ratings, as identified:

- Control of Contractors: Follow-up – Substantial Assurance; and
- Occupational Health: Follow-up – Draft Reasonable Assurance.

Through 2022/23, the Corporate Governance team has continued to review all outstanding recommendations with management and the outcomes have been reported to each meeting of the Audit, Risk & Assurance Committee.

We undertook work towards the end of the year to review the tracking process and validate the stated position for a sample of recommendations. We were able to confirm the recorded position for all of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker. *- This work is on-going so will need to confirm this wording as it is completed.*

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk

management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on previous year's programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023. The CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it fully conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any member of NWSSP's Audit & Assurance Service who undertook work on the Powys audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;

- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales;
- Welsh Health Specialised Services Committee; and
- Emergency Ambulance Services Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Objectives
Accounts Payable	Reasonable	To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP P2P service.
Payroll	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the

		management of Payroll Services.
Primary Care Services – Medical (GMS), Pharmaceutical (GPS), Dental (GDS), and Ophthalmic (GOS) Services	Reasonable Substantial Substantial Substantial	To evaluate and determine the adequacy of controls in place to administer timely and accurate payments to primary care contractors.
Other audits: Recruitment Services Procurement	 Reasonable (WiP)	 To assess the adequacy and effectiveness of systems and controls for the management of Recruitment Services

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is *(to be determined)* Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Objectives
Switching Services	Reasonable	
Embedding the Stakeholder Engagement Plan	Reasonable	
Centre of Excellence	(WiP)	
Technical Resilience	Substantial	
Cyber Security	(WiP)	

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is *(to be determined)* Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Objectives
WHSSC – Quality Unit	Substantial	To evaluate and determine the adequacy of the systems and controls in place within WHSSC in relation to quality assurance reporting.
WHSSC – Neurosciences and long-term conditions	Substantial	To evaluate and determine the adequacy of the systems and controls in place for the Neurosciences and Long-Term Conditions Programme.
EASC – Ambulance handover improvement arrangements	Substantial	We focused on the adequacy of the systems and controls in place within EASC for the development of the seven Welsh health boards' ambulance handover improvement plans and their Integrated Commissioning Action Plans (ICAPs) and ongoing monitoring.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in March 2022 contained 23 planned reviews. Changes have been made to the plan through the year with 2 audit cancelled and 3 audits added. All these changes have been reported to and approved by the Audit Committee. As a result, we have delivered a total of 24 reviews.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. The key performance indicators are summarised as follows:

Indicator Reported to Audit and Assurance 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
Total assignments reported against adjusted plan for 2022/23	A	88% (22/25)	100%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	83%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%

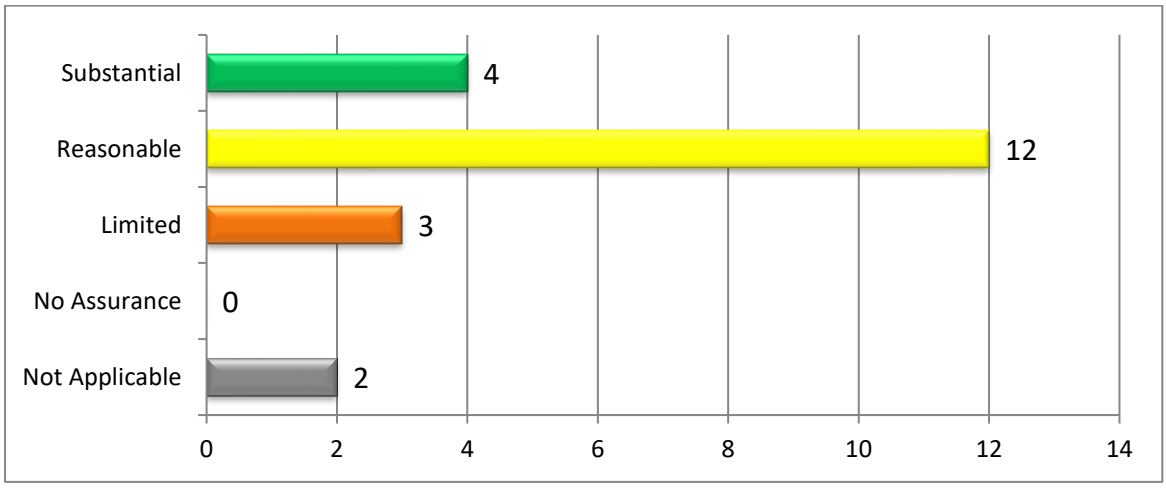
5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 24 *(table currently showing 22 and will need to be updated following completion of work in progress)* audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings



* Need to add in outcomes for the 3 audits that are still to be completed.

Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were two audits which did not proceed following preliminary planning and agreement with management. It was recognised that the underlying position and associated risks had changed and audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Control of Contractors: Follow-up	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 21/22 'Control of Contractors' Audit, which reported 'Limited' assurance.
Looked After Children Health Assessments	To provide assurance that effective processes are in place to ensure that LAC health assessments are appropriately completed for all relevant looked after children, in accordance with the requirements of the Framework.
Cancer Services - Access to Symptomatic FIT	To provide assurance that the planned actions to allow improved access to symptomatic FIT are being effectively delivered.
Women & Children's Services	To evaluate and determine the adequacy of the systems and controls in place within the Women and Children's service, in order to provide assurance that risks material to the achievement of the system's objectives are managed appropriately.

5.3 Reasonable Assurance (Yellow)

In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Staff Rostering	To review the controls and processes in place for the planning and management of staff rosters focusing on the nursing rosters.
Security Services	To assess the structure and effectiveness of Security Services within the Health Board.
Machynlleth Hospital Reconfiguration Project	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
North Powys Wellbeing Programme	To evaluate and determine the adequacy of the systems and controls in place for the North Powys Wellbeing Programme to provide assurance that risks material to the achievement of system objectives are managed appropriately.
Charitable Funds	To review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.
Workforce Futures Strategic Framework	To provide assurance that the framework has started to embed and is providing clear direction of the future work required to achieve the outcomes intended.
Incident Management	To review the arrangements in place within the Health Board for the identification, recording, investigation and management of incidents.
Therapies and Health Sciences Professional Governance Structure	To review the implementation of a structure to provide assurance on professional oversight.
Temporary Staffing Department	To evaluate and determine the adequacy of the systems and controls in place within the Temporary Staffing Unit, to provide assurance that risks material to the achievement of the systems objectives are managed appropriately.
Risk Management and Board Assurance Framework (Draft)	To evaluate and determine the adequacy of the systems and controls in place within the Health

Review Title	Objective
	Board in relation to Risk Management and the Board Assurance Framework.
Performance Management & Reporting (Draft)	To provide assurance on the effectiveness of the Health Board's performance management and reporting arrangements, ensuring the achievement of an Integrated approach through the Improving Performance Framework.
Occupational Health Follow-up (Draft)	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Limited Assurance Occupational Health Service review that was reported as part of our 2021/22 work programme.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
IT Infrastructure and Asset Management	to provide assurance that a process is in place for ensuring that the infrastructure hardware is tracked, maintained, supported and that the network is managed sufficiently to provide services for the organisation.
Welsh Language Standards	To assess the processes in place within the Health Board to ensure compliance with the requirements of the Welsh Language Standards Act.
Cyber Security	to ensure that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Site Leadership & Coordination	To assess the effectiveness of operational site management and coordination arrangements within the Health Board.
Decarbonisation	To affirm common decarbonisation themes, to provide an overview of the overarching position across NHS Wales

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for Deferral
Covid 19 – Outbreak Control Plan, Contact Tracing	The review was no longer appropriate due to the changing Covid 19 situation.
Planned Care / Recovery of Backlog Services	The Health Board were provided with assurance on this area through the 'Review of the Strategic Portfolio' work undertaken by Audit Wales.

5.8 Work in Progress

At the time of producing the draft Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. It is anticipated that the majority of this work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

Review Title	Objective
Follow-up Action Tracker (WiP)	To review the systems in place to monitor progress with the implementation of actions in response to internal audit recommendations.
SLAs for IN-reach Medical Staff (WiP)	To Provide assurance over actions taken to review and update SLA arrangements for in-reach medical staff across all Health Board services.
Savings Plans & Efficiency Framework (WiP)	to provide assurance on the development, monitoring and achievement of the Health Board's savings plans linked to recovery and the associated Efficiency Framework.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Ian Virgill
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership
May 2023

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of

	specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.

2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - 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.

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Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.2

Audit, Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**Audit & Assurance External Quality Assessment of Conformance to the Public Sector Internal Audit Standards**
Approved and Presented by:	**Director of Corporate Governance / Head of Internal Audit**
Prepared by:	**Head of Internal Audit**
Other Committees and Meetings considered at:	

PURPOSE:

To inform the Audit, Risk and Assurance Committee about the outcome of the latest Audit & Assurance Service External Quality Assessment.

RECCOMENDATION(S):

The Audit, Risk & Assurance Committee are requested to:

- Recive **assurance** on the quality of the Internal Audit services through the positive outcome of the External Quality Assessment**.**

Approval	Discussion	Information
	X	X

Patterson,Liz 12/05/2023 15:46:31

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 latest External Quality Assessment (EQA) of the Audit & Assurance Service was undertaken in March 2023 by the Chartered Institute of Public Finance and Accountancy (CIPFA).

CIPFAs final report on the outcome of the EQA was delivered in April 2023 and provided the following opinion:

'It is our opinion that the self-assessment for the NHS Wales Shared Services Partnership's Audit and Assurance Service is accurate, and we therefore conclude that the Audit and Assurance Service FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note'.

BACKGROUND AND ASSESSMENT:

Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS). All public sector internal audit services are required to measure how well they are conforming to the standards.

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service is required to have an external assessment of its conformance to the PSIAS carried out every 5 years.

NEXT STEPS:

External Quality Assessment of Conformance to the Public Sector Internal Audit Standards

NHS Wales Shared Services Partnership's Audit and Assurance Service

Final Report

Lead Associate: Ray Gard, CPFA, FCCA, CFIIA, DMS

Quality Assessment: Diana Melville, FCPFA

8 April 2023

NHS Wales Shared Services Partnership's Audit and Assurance Service

Table of contents

1. Introduction

1.1 Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS), which have been in place since 1st April 2013 (revised 2016 and 2017). All public sector internal audit services are required to measure how well they are conforming to the standards. This can be achieved through undertaking periodic self-assessments, external quality assessments (EQA), or a combination of both methods. However, the standards state that an external reviewer must undertake a full assessment or validate the Internal Audit Service's own self-assessment at least once in a five-year period.

2. Background

2.1 The Audit and Assurance Service provides internal audit and consultancy services to the NHS Wales Shared Services Partnership NWSSP), the seven geographic Health Boards, and the five Trusts and Specialist Health Authorities in Wales. The service is managed by the Director of Audit and Assurance and is organised into four regional teams namely Audit North Wales; Audit South East & Swansea; Audit Hywel Dda; Audit South Central; and a fifth team, the Specialist Services Unit (SSU), that provides capital project and specialist estates assurance services for the whole of NHS Wales. As is common with NHS shared services, a single NHS trust takes on responsibility for hosting the shared service. For NWSSP, including the Audit and Assurance Service, the host trust is the Velindre University NHS Trust.

2.2 The Director of Audit and Assurance is supported by seven Heads of Internal Audit (one each for Audit North Wales; Audit Hywel Dda; and the SSU; and two each for the Audit South Central & Swansea; and Audit South Central regions who each have a larger portfolio of clients. Audit and Assurance is a large experienced and well qualified NHS internal audit agency with, at the time of the EQA, a workforce comprising 52 employees. The Director of Audit and Assurance, and the Heads and the Deputy Heads of Internal Audit all hold relevant professional qualifications, being mainly CCAB accountants with four chartered internal auditors. Below this are the Audit Managers and Principal Auditors, the majority of which also hold relevant professional qualifications or are working towards obtaining them.

2.3 From an operational perspective, the Audit and Assurance Service is part of the NWSSP and reports to the Managing Director and the NWSSP's Audit Committee. Regarding Audit and Assurance's other clients, the Heads of Internal Audit report to the respective Board Secretaries and Executive Boards, and their Audit Committees. The Public Sector Internal Audit Standards requires internal audit services to define the roles of 'Senior Management' and 'the Board' in the audit charter. The Board Secretaries and the Executive Boards fulfil the role of 'Senior Management' and the Audit Committees fulfil the role of 'the Board' at each of the Audit and Assurance Service's clients. 'Senior Management' and the 'Board' at each client receive regular reports from the Heads of Internal Audit on their audit plans, progress being made on delivering the plans, details of the completed audit reviews, and the annual opinion and outturn.

2.4 Audit and Assurance has an audit manual that provides the auditors with a comprehensive guide to all aspects of performing an internal audit or consultancy assignment and is cross referenced to the PSIAS. The Service uses standard templates for all engagement working papers, testing schedules, and audit reports, and these are embedded in their TeamMate audit management system. Supervision of the engagements takes place at every stage of the process and is recorded on the appropriate documentation in the TeamMate.

2.5 There is a quality assurance process in place that includes internal and external quality assessments of the Service, reviews of live engagements, and final clearance of all

completed reports by the relevant Head of Internal Audit, or the Director of Audit and Assurance where appropriate, and post audit satisfaction client surveys. In addition, the Director of Audit and Assurance randomly selects a sample of audit reports each year and performs an in-depth quality assurance review, All these processes feed into the Audit and Assurance Service's Quality Assurance and Improvement Programme (QAIP).

2.6 The Audit and Assurance Service has been operating under PSIAS since its launch in 2013, and this is the second external quality assessment (EQA) that they have commissioned.

3. Validation Process

3.1 This validation of the Service's self-assessment comprised a combination of a review of the evidence provided by Audit and Assurance; a review of a sample of completed internal audits for the Service's clients; a survey that was sent to and completed by a range of stakeholders; and interviews with key stakeholders from a sample of the Service's clients, using MS Teams. The interviews focussed on determining the strengths and weaknesses of Audit and Assurance and assessed the Service against the four broad themes of Purpose and Positioning; Structure and Resources; Audit Execution; and Impact.

3.2 The Audit and Assurance Service provided a comprehensive range of documents that they used as evidence to support their self-assessment, and these were available for examination prior to and during this validation review. These documents included the:

- self-assessment against the standards;
- quality assurance and improvement plan (QAIP);
- evidence file to support the self-assessment;
- the audit charters;
- the annual reports and opinions;
- the audit plans and strategies;
- audit procedures manual;
- a range of documents and records relating to the team members;
- progress and other reports to the respective Audit and Standards Committees.

All the above documents were examined during this EQA.

3.3 The main phase of the validation process was carried out during the week commencing 6 March 2023, with further work and interviews undertaken during the following weeks. This phase of the EQA involved a review of a sample of audit files covering the Service's clients, and interviews with a wide sample of key stakeholders from the Service's clients. Overall, the feedback from the interviewees was positive with clients valuing the professional and objective way the Audit and Assurance Service delivered their services.

3.4 A survey was sent to a range of other key stakeholders and the results analysed during the review. Details of the survey findings have been provided to the Internal Audit Manager and a brief summary has been included in this report.

3.5 The assessor reviewed examples of completed audits, to confirm his understanding of the audit process used by the Audit and Assurance Service, and to determine how Audit and Assurance has applied the PSIAS in practice.

4. Opinion

It is our opinion that the self-assessment for the NHS Wales Shared Services Partnership's Audit and Assurance Service is accurate, and we therefore conclude that the Audit and Assurance Service FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.

4.1 The table below shows the Audit and Assurance Service's level of conformance to the individual standards assessed during this external quality assessment:

Standard / Area Assessed	Level of Conformance
Mission Statement	**FULLY Conforms**
Core principles	**FULLY Conforms**
Code of ethics	**FULLY Conforms**
Attribute standard 1000 – Purpose, Authority and Responsibility	**FULLY Conforms**
Attribute standard 1100 – Independence and Objectivity	**FULLY Conforms**
Attribute standard 1200 – Proficiency and Due Professional Care	**FULLY Conforms**
Attribute standard 1300 – Quality Assurance and Improvement Programmes	**FULLY Conforms**
Performance standard 2000 – Managing the Internal Audit Activity	**FULLY Conforms**
Performance standard 2100 – Nature of Work	**FULLY Conforms**
Performance standard 2200 – Engagement Planning	**FULLY Conforms**
Performance standard 2300 – Performing the Engagement	**FULLY Conforms**
Performance standard 2400 – Communicating Results	**FULLY Conforms**
Performance standard 2500 – Monitoring Progress	**FULLY Conforms**
Performance standard 2600 – Communicating the Acceptance of Risk	**FULLY Conforms**

5. Areas of full conformance with the Public Sector Internal Audit Standards

5.1 Mission Statement and Definition of Internal Audit

The mission statement and definition of internal audit from the PSIAS are included in the audit charter.

5.2 Core Principles for the Professional Practice of Internal Auditing

The Core Principles, taken as a whole, articulate an Internal Audit function's effectiveness, and provide a basis for considering the organisation's level of conformance with the Attribute and Performance standards of the PSIAS.

The clear indication from this EQA is that the Core Principles are embedded in Audit and Assurance's procedures and working methodologies and they are a very competent, experienced, and professional Service that conforms to all ten elements of the Core Principles.

5.3 Code of Ethics

The purpose of the Institute of Internal Auditors' Code of Ethics is to promote an ethical culture in the profession of internal auditing, and is necessary and appropriate for the profession, founded as it is on the trust placed in its objective assurance about risk management, control, and governance. The Code of Ethics provides guidance to internal auditors and in essence, it sets out the rules of conduct that describe behavioural norms expected of internal auditors and are intended to guide their ethical conduct. The Code of Ethics applies to both individuals and the entities that provide internal auditing services.

The clear indication from this EQA is that the Audit and Assurance Service conforms to the Code of Ethics, and this is embedded in their procedures, and their audit methodologies. The code of ethics is part of their overarching culture and underpins the way the Service operates.

5.4 Attribute Standard 1000 – Purpose, Authority and Responsibility

The purpose, authority and responsibility of the Internal Audit activity must be formally defined in an internal audit charter, consistent with the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards, and the Definition of Internal Auditing). The internal audit charter must be reviewed regularly and presented to senior management and the audit panel for approval.

There is a separate audit charter in place for each of the Service's clients and these are reviewed on an annual basis. We reviewed these documents and found them to be comprehensive and well written. We are satisfied that the Audit and Assurance Service conforms to attribute standard 1000.

5.5 Attribute Standard 1100 – Independence and Objectivity

Standard 1100 states that the Internal Audit activity must be independent, and internal auditors must be objective in performing their work.

The need for independence and objectivity is an integral part of the Service's culture. The Service reports in its own name and directly to the Board Secretaries and Executive Boards, and the Audit Committees at all the Service's clients. All employees declare any potential impairment to their independence or objectivity for each audit they undertake.

We have reviewed the Audit and Assurance Service's comprehensive audit manual, procedures, and their standard documentation; their quality assurance and improvement plan; and a sample of completed audit files for all of the Service's clients. We have also reviewed their reporting lines and their positioning within the respective organisations. Neither the Director of Audit and Assurance nor the Heads of Internal Audit have any other roles and responsibilities in addition to Audit and Assurance at NWSSP or any of the Service's other clients. The audit charter confirms that there are no impairments to their independence or the Audit and Assurance Service, although this is not reinforced in the Heads of Internal Audit's annual reports. As the annual report looks back on the year just finished, whereas the audit charter and plan are designed to look forward, it is recognised as good practice to confirm whether there have been any impairments to independence during the year. We have made one advisory suggestion regarding this observation. We are satisfied that the Audit and Assurance Service conforms with attribute standard 1100.

5.6 **Attribute Standard 1200 – Proficiency and Due Professional Care**

Attribute standard 1200 requires the Internal Audit Services' engagements are performed with proficiency and due professional care, having regard to the skills and qualifications of the staff, and how they apply their knowledge in practice.

It is evident from this EQA that the Audit and Assurance Service has a professional and experienced workforce. As mentioned in the background section above, the Director of Audit and Assurance, and the Heads and the Deputy Heads of Internal Audit all hold relevant professional qualifications, being mainly CCAB accountants with four chartered internal auditors. Below this are the Audit Managers and Principal Auditors, the majority of which also hold relevant professional qualifications or are working towards obtaining them.

The Audit and Assurance Service has a specialist IT audit team that undertakes all of the technical IT audits across NHS Wales, although all the team members have sufficient knowledge of the operation of high-level IT controls that they can incorporate these into their testing for the audits they undertake. In addition, the Service also undertakes a regular comprehensive programme of transactional audits for NWSSP who provide all the transactional processing for all of NHS Wales and are currently exploring the potential to expand this by using specialist data analytics software applications.

It is evident from this review that the Audit and Assurance Service's employees are experienced and well qualified and perform their duties with due professional care. We are satisfied that the Audit and Assurance Service complies with attribute standard 1200.

5.7 **Attribute Standard 1300 – Quality Assurance and Improvement Programmes**

This standard requires the Head of Audit to develop and maintain a quality assurance and improvement programme that covers all aspects of the Internal Audit activity.

The Audit and Assurance Service has developed an effective quality assurance process which feeds into their quality assurance and improvement programme that ensures engagements are performed to a high standard. Supervision of audit engagements is carried out at all stages of the audit. Evidence of the supervision of the assignments is recorded throughout the audit process. We have examined the supporting evidence provided by the Audit and Assurance Service during this EQA and are satisfied that they conform to attribute standard 1300.

5.8 **Performance Standard 2000 – Managing the Internal Audit Activity**

The remit of this standard is wide and requires the Chief Audit Executive to manage the Internal Audit activity effectively to ensure it adds value to its clients. Value is added to a client and its stakeholders when Internal Audit considers their strategies, objectives,

and risks; strives to offer ways to enhance their governance, risk management, and control processes; and objectively provides relevant assurance to them. To achieve this, the Chief Audit Executive must produce an audit plan and communicate this and the Service's resource requirements, including the impact of resource limitations, to senior management and the Audit and Risk Committee for their review and approval. The Chief Audit Executive must ensure that Internal Audit's resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.

The standard also requires the Chief Audit Executive to establish policies and procedures to guide the Internal Audit activity, and to share information, co-ordinate activities and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimise duplication of efforts.

Last, but by no means least, the standard requires the Chief Audit Executive to report periodically to senior management and the Audit Committees on Internal Audit's activities, purpose, authority, responsibility, and performance relative to its plan, and on its conformance with the Code of Ethics and the Standards. Reporting must also include significant risk and control issues, including fraud risks, governance issues and other matters that require the attention of senior management and/or the audit panels.

The Audit and Assurance Service has a range of procedures in place that are incorporated in their comprehensive audit manual that is cross-referenced to the PSIAS.

The Service have developed comprehensive planning processes that take into consideration the risks and objectives of each client; their risk management and governance frameworks; any other relevant and reliable sources of assurance that are available; key issues identified by managers at each client; the Service's own risk and audit needs assessments; and any emerging risks identified through horizon scanning and networking with other organisations. The Service produces a risk-based audit plan for each client that is designed to provide them with relevant assurance on their Board Assurance Framework and their governance, risk management and internal controls. The audit plans are reviewed and approved by the Executive Boards and the Audit Committees of the respective clients.

Details of the completed audits, together with regular updates on the progress being made on delivering the audit plans and the performance of the Audit and Assurance Service, are reported to the respective Board Secretaries and Executive Boards and the Audit Committees at each client. Annual reports and opinions are also issued at the end of the year and presented to the respective Executive Boards and Audit Committees.

The clear indication from this EQA is that the Audit and Assurance Service is managed effectively and conforms to standard 2000.

5.9 **Performance Standard 2100 – Nature of Work**

Standard 2100 covers the way the Internal Audit activity evaluates and contributes to the improvement of the organisation's risk management and governance framework and internal control processes, using a systematic, disciplined and risk-based approach.

This is the approach adopted by the Audit and Assurance Service and is embedded in their working methodologies. During this EQA, we reviewed a sample of completed audits and examined them to see if they conformed to standard 2100 and Audit and Assurance's own methodologies. We found that all the sample audit files examined during the EQA complied with all three.

The clear indication from this EQA is that the Audit and Assurance Service conforms to performance standard 2100.

5.10 **Performance Standard 2200 – Engagement Planning**

Performance standard 2200 requires Internal Auditors to develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. The plan must consider the organisation's strategies, objectives, and risks relevant to the engagement.

As mentioned above, the Service have a comprehensive and robust audit manual and supervision processes in place that include engagement planning and meets the requirements of the PSIAS. From the sample of audit files that we examined during the EQA we found that they all conformed to standard 2200 and the Service's own audit procedures, and therefore we conclude that Audit and Assurance conforms to performance standard 2200.

5.11 **Performance Standard 2300 – Performing the Engagement**

Performance standard 2300 seeks to confirm that Internal Auditors analyse, evaluate and document sufficient, reliable, relevant, and useful information to support the engagement results and conclusions, and that all engagements are properly supervised.

As we have mentioned above, the Audit and Assurance Service has a comprehensive audit manual, sound supervision arrangements, and quality assurance processes in place that meet the requirements of the standards. We reviewed the evidence provided in support of the Service's self-assessment, together with a sample of audit files held in the TeamMate audit management system to see if they conformed to the standards, and Audit and Assurance's own working methodologies. We found that all the evidence we examined conformed to the standards and Audit and Assurance's own procedures and methodologies. We therefore conclude that the Audit and Assurance Service conforms to performance standard 2300.

5.12 **Performance Standard 2400 – Communicating Results**

This standard requires Internal Auditors to communicate the results of engagements to clients and sets out what should be included in each audit report, as well as the annual report and opinion. When an overall opinion is issued, it must take into account the strategies, objectives and risks of the clients and the expectations of their senior management, the audit panels and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant, and useful information. Where an internal audit function is deemed to conform to the PSIAS, reports should indicate this by including the phrase "conducted in conformance with the International Standards for the Professional Practice of Internal Auditing".

The Service's audit manual and supervision processes cover the communication of results of individual audits and meet the requirements of the PSIAS. During the EQA we reviewed the evidence provided in support of the Service's self-assessment and the audit reports issued for a sample of audits to establish if they conformed to the standards. All the evidence we examined conformed to the standards and Audit and Assurance's own procedures and methodologies.

We also reviewed the progress and annual reports presented to the respective Audit Committees and found that these also conformed to the standards and the Service's own internal procedures.

We therefore conclude that the Audit and Assurance Service conforms to performance standard 2400.

5.13 **Performance Standard 2500 – Monitoring Progress**

There is a comprehensive follow-up process in place, the objective of which is to monitor the client's progress towards the implementation of agreed actions. The results of the

follow-up reviews are reported to the respective Audit Committees. From this EQA, it is evident that the Audit and Assurance Service conforms to performance standard 2500.

5.14 **Performance Standard 2600 – Communicating the Acceptance of Risk**

Standard 2600 considers the arrangements which should apply if the Director of Audit and Assurance and the relevant Head of Internal Audit has concluded that management have accepted a level of risk that may be unacceptable to the organisation. Situations of this kind are expected to be rare, consequently, we did not see any examples of this during this review. From this EQA, it is evident that the Audit and Assurance Service conforms to performance standard 2600.

6. Areas of partial conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

6.1 There are no areas of partial conformance with the Public Sector Internal Audit Standards.

7. Areas of non-conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

7.1 There are no areas of non-conformance with the Public Sector Internal Audit Standards.

8. Survey results

8.1 Overall, the results of the survey of key stakeholders from the Audit and Assurance Service's clients were positive with respondents valuing the services provided by them. The overall number of positive responses were very high with nearly all respondents agreeing or partially agreeing with the survey statements. The detailed findings from the survey have been shared with the Director of Audit and Assurance and a summary of the survey results has been included in this report at page 14.

9. Issues for management action

9.1 We have identified two advisory issues for management to consider, as set out in the table below.

Issues for management action	Priority
The audit charter confirms that there are no impairments to the independence of the Director of Audit and Assurance, the Heads of Internal Audit, or the Audit and Assurance Service although we have noted that this is not reinforced in the respective annual reports. As the annual report looks back on the year just finished, whereas the audit charter and plan are designed to look forward, it is recognised as good practice to confirm whether there have been any impairments to independence during the year.	**Advisory**

Issues for management action	Priority
Management should be mindful of the fact that a consultation on revising the Institute of Internal Auditors global International Professional Practice Framework (IPPF) which is incorporated into the PSIAS, commenced on 1 March 2023. Whilst this will not impact on the Service's current level of conformance, any changes to the Standards arising from the consultation may affect the Service's conformance in the medium term. It is therefore suggested that the Director of Audit and Assurance considers the contents of the consultation document and keeps a watching brief on the developments to the Standards and how this may impact the Service in the medium term.	**Advisory**

10. Definitions

Level of Conformity	Description
FULLY Conforms	The Internal Audit Service complies with the standards with only minor or no deviations. The relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the individual Standard and the Code of Ethics in all material respects. This means that there is conformance to all of the individual Standards and the Code of Ethics.
Partially Conforms	The Internal Audit Service is endeavouring to deliver an effective service however, they are falling short of achieving some of their objectives and/or generally conforming to a majority of the individual Standards and elements of the Code of Ethics and at least partial conformance to the others. There will usually be significant opportunities to improve the delivery of effective internal audit and enhance conformance to the Standards or elements of the Code of Ethics. The Internal Audit Service may be aware of some of these opportunities and the areas they need to develop. Some identified deficiencies may be beyond the control of Internal Audit and may result in actions for Senior Management or the Board of the organisation to address.
Does Not Conform	The Internal Audit Service is not aware of; not making efforts to comply with; or is failing to achieve many/all of the individual Standards or elements of the Code of Ethics. These deficiencies will usually have a significant adverse impact on Internal Audit's effectiveness and its potential to add value and are likely to represent significant opportunities for improvement to Internal Audit. Some identified deficiencies may be beyond the control of Internal Audit and may result in recommendations to Senior Management or the Board of the organisation.

Action Priorities	Criteria
High priority	The Internal Audit Service needs to rectify a significant issue of non-conformance with the standards. Remedial action to resolve the issue should be taken urgently.
Medium priority	The Internal Audit Service needs to rectify a moderate issue of conformance with the standards. Remedial action to resolve the issue should be taken, ideally within a reasonable time scale, for example six months.
Low priority	The Internal Audit Service should consider rectifying a minor issue of conformance with the standards. Remedial action to resolve the issue should be considered but the issue is not urgent.
Advisory	These are issues identified during the course of the EQA that do not adversely impact the service's conformance with the standards. Typically, they include areas of enhancement to existing operations and the adoption of best practice.

The co-operation of the Director of Audit and Assurance, the Heads of Internal Audit, the Business Support Manager, and the Deputy Head of Internal Audit at Audit Hywel Dda in providing the information requested for the EQA, is greatly appreciated. Our thanks also go to the Board Secretaries and chairs of the respective Audit Committees, and the key stakeholders from all the Service's clients that made themselves available for interview during the EQAs and/or completed the survey.

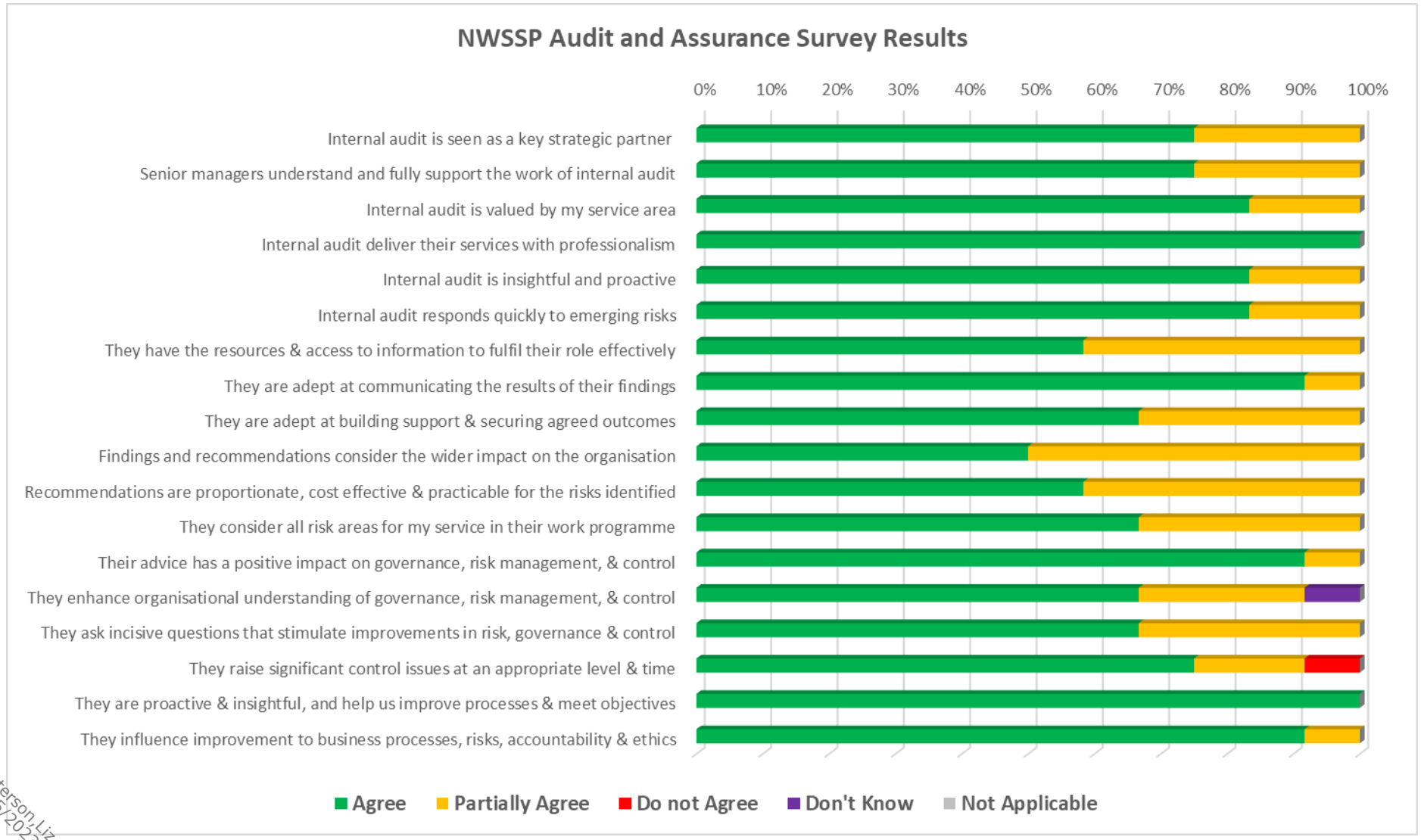
Ray Gard, CPFA, FCCA, FCIIA, DMS

8 April 2023

11. Disclaimer

This report has been prepared by CIPFA at the request of the NHS Wales Shared Services Partnership's Audit and Assurance Service, and the terms for the preparation and scope of the report have been agreed with them. The matters raised are only those that came to our attention during our work. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, we have only been able to base findings on the information and documentation provided to us. Consequently, no complete guarantee can be given that this report is necessarily a comprehensive statement of all the issues that exist with their conformance to the Public Sector Internal Audit Standards that exist, or of all the improvements that may be required.

The report was prepared solely for the use and benefit of NHS Wales Shared Services Partnership's Audit and Assurance Service, including the Executive Boards and Audit Committees of NWSSP and the Service's clients, and to the fullest extent permitted by law, CIPFA accepts no responsibility and disclaims all liability to any other third party who purports to use or rely, for any reason whatsoever on the report, its contents, conclusions, any extract, and/or reinterpretation of its contents. Accordingly, any reliance placed on the report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification by any third party is entirely at their own risk.



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Archwilio Cymru
Audit Wales

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

Date issued: May 2023

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

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

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

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit, Risk and Assurance Committee Update

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Powys Teaching Health Board. We presented our most recent Audit Plan to the committee on May 2023.

2 We also provide additional information on:

- other relevant examinations and studies published by the Audit General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

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

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2022-23 Accountability Report and Financial Statements	Director of Finance & ICT	Statutory audit of the financial statements to inform the audit opinion.	Audit of the accounts due to commence on 9 May following receipt of the draft accounts on 5 May.	July 2023

Performance audit update

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

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Orthopaedic services – follow up	Interim Director of Operations	This review examined the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are taking 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 have been summarised into a single national report with supplementary outputs setting out the local position for each health board.	Complete. National and local report published on 2 March 2023	July 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Medical Director	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Blog and data tool published in April 2022 Part 1 - Fieldwork complete and report drafting now underway. Part 2 – Due to start in May 2023.	TBC
Structured Assessment	Director of Corporate Governance/ 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:	Complete.	May 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Governance and leadership; • Financial management; • Strategic planning; and Use of resources (such as digital resources, estates, and other physical assets).		
Primary Care Services - Follow-up Review	Interim Director of Operations	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 primary care as set out in the national plan. Our report published in 2019 made several recommendations to the Health Board. This work will follow-up progress against these recommendations.	Set up meeting held on 2 May. Fieldwork underway.	July 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Workforce Planning	Director of Workforce & OD	This review will assess the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Fieldwork underway.	September 2023

Other relevant publications

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

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

Title	Publication Date
Digital Inclusion in Wales Key questions for public bodies	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog Powys Teaching Health Board – Tackling the Orthopaedic Services' Waiting List Backlog	March 2023
Betsi Cadwaladr University Health Board – Review of Board Effectiveness	February 2023
'Together we can' – Community resilience and self-reliance	January 2023

Additional information

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

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Audit Wales Annual Plan 2023-24	April 2023

8 **Exhibit 5** provides details of any relevant Audit Wales consultations currently underway. There are no relevant Audit Wales consultations currently underway.

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

Archwilio Cymru
Audit Wales

Structured Assessment 2022 – Powys Teaching Health Board

Audit year: 2022

Date issued: May 2023

Document reference: 3560A2023

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

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

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2022 structured assessment work at Powys Teaching Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. The approach we adopted to deliver our work is detailed in summarised in **Appendix 1**.

4 We have also provided updates on progress against recommendations identified in previous structured assessment reports.

Key messages

5 Overall, we found that the Health Board has generally good governance arrangements in place, but it needs to update the Board Assurance Framework to have a clear understanding of risks, ensure there are no key governance gaps, and help develop and prioritise workplans.

6 The Health Board has a well-established long-term strategy and a clear focus on its clinical priorities. An approved Integrated Medium-Term Plan (IMTP) is in place, which was developed with Board engagement. However, there is scope to engage the Board earlier in the planning process. There are good arrangements for developing plans, with a clear focus on value-based healthcare and commissioned services. Clear arrangements for monitoring delivery of the IMTP and supporting plans are also in place but greater focus is needed on measures and impact.

7 The Health Board has some effective sources of assurance in place, but it still does not have an updated Board Assurance Framework. The Board and committees are generally operating well. However, opportunities exist to improve public access to key Health Board documents, address some gaps in assurance, strengthen staff feedback, and improve Board self-review mechanisms. Despite some new appointments, there remains continued change at an Executive level which can lead to instability with a risk that the operations portfolio is disproportionate. Interim governance arrangements have now been addressed; however, capacity to support the governance function is an issue.

8 The Health Board met its financial duties for 2021-22, but despite having a balanced financial plan, is now forecasting a year-end financial deficit for 2022-23. This means it will fail its financial duties for revenue. The Health Board has appropriate arrangements for financial management and control, which have been escalated at an operational level to minimise the impact of financial pressures during the year. Oversight and scrutiny of the Health Board's financial position has improved with more timely information now reported to Board and relevant committees.

9 The Health Board has appropriate arrangements in place to support and oversee staff wellbeing, but it could do more to monitor progress against our previous recommendations. Digital is recognised as a key enabler and the Health Board is developing its digital framework, but the digital infrastructure and availability of funding are significant issues. The Health Board has generally good oversight of the management of estates although visibility and discussion could be improved at Board.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 2**.

Exhibit 1: 2022 recommendations.

Recommendations
Improving strategic planning arrangements
R1 Opportunities exist to engage Independent Members in the early stages of the IMTP planning process to enable the Board to fully discharge its duty to set the strategic direction for the organisation. The Health Board, therefore, should put appropriate arrangements in place to ensure appropriate Independent Member involvement in all IMTP planning stages.

Recommendations

R2 Delivery reports for monitoring progress against the priorities and actions set out in the IMTP are largely narrative and lack a focus on measures and impact. The Health Board, therefore, should revisit its delivery reports to ensure they are succinct, less narrative, and have an increased focus on measures and impact.

Further enhancing systems of assurance

R3 The Health Board does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee workplans. The Health Board, therefore, needs to update its Board Assurance Framework.

R4 There is currently a disconnect between directorate risk registers and the Corporate Risk Register (CRR). The Health Board, therefore, needs to review all high risks on directorate risk registers to ensure the relevant ones are escalated to the CRR, and that the Board is aware of wider risks that may materialise.

Improving Board and committee effectiveness

R5 Opportunities exist to improve public access to key Health Board documents. The Health Board should ensure that:

a) policies and procedures, and the register of interest on the public website are accessible; and
b) key documents, including Standing Orders, on the public website are the most recently approved version.

R6 There are no mechanisms for committee Chairs to meet formally outside of committee meetings to share concerns and good practice, and there are also no mechanisms in place to track issues and actions referred between committees. The Health Board, therefore, should put in place a mechanism to enable:

a) committee chairs to come together on a regular basis; and
b) issues and actions referred between committees to be tracked and feedback provided when completed.

Recommendations

R7 The Board and its committees do not hear from staff, and Board walkarounds have not been reinstated since the pandemic. The Health Board, therefore, should increase opportunities for Board members to hear from staff. This should include making use of staff stories in Board and committee meetings, and the urgent reinstatement of Board walkarounds.

R8 Despite Standing Order requirements, the Health Board still does not have a Healthcare Professionals Forum or a Stakeholder Reference Group. The Health Board, therefore, should establish both groups as a matter of urgency.

R9 Opportunities exist to improve self-reviews of Board and committee effectiveness. The Health Board, therefore, should:

a) ensure areas for improvement are captured and monitored via an action plan; and
b) include a standing agenda item in all Board and committee meetings to allow for a review of the meeting.

Recruiting to key positions

R10 The Health Board is carrying several interim posts at a senior level which can cause instability for both services and staff. The Health Board, therefore, should seek to appoint substantively to the interim posts within the Executive team as soon as practical to do so.

Strategic planning arrangements

11 In this section of the report, we provide our views on the Health Board's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-Term Plan (IMTP);
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

12 We found that **the Health Board has a well-established long-term strategy which is supported by an approved IMTP. It has good arrangements in place to develop and monitor delivery of its plans, but there is scope to engage the Board earlier in the planning process and to increase its focus on measures and impact.**

Vision and strategic objectives

13 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:

- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the vision and strategic objectives have been developed and adopted by the Board; and
- the long-term strategy is underpinned by an appropriate long-term clinical strategy.

14 We found that **the Health Board has a well-established long-term strategy and a clear focus on its clinical priorities.**

15 The Health Board has a well-established Health and Care Strategy, spanning 2017- 2027, which outlines its vision for a Healthy, Caring Powys. The strategy was developed in partnership with Powys County Council and in consultation with stakeholders, partners, and the public taking on board their experience and opinions of health in Powys. The strategy is informed by the Powys Public Service Board Well-being Assessment and the Regional Partnership Board Population Needs Assessment. It is based around three themes - Start Well, Live Well, and Age Well - with several priorities and enablers to drive this ambition forward.

16 Alongside the strategy is the Health Board's Renewal Portfolio, which blends recovery and transformation and focuses on six clinical renewal priorities. These priorities are based on the Health Board's internal appraisal of the impacts of the pandemic and rooted in the priority needs of the Powys population. They build on the principles of the strategy and the Health Board's plan to ensure a focus on

those things that matter most to the well-being of its population and those things which will work best to address the critical challenges ahead.

Integrated Medium-Term Plan

17 We considered the extent to which the Health Board has been able to produce an approvable Integrated Medium-Term Plan (IMTP) for 2022-2025. In examining this, we have looked at whether:

- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
- the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission; and
- the IMTP received approval from the Minister for Health and Social Services.

18 We found that **the Health Board has an approved IMTP, but there is scope to engage the Board much earlier in the planning process.**

19 The Health Board has been able to produce a Welsh Government approved IMTP for 2022-2025. The draft IMTP was approved by the Board in March 2022 and submitted to the Welsh Government by the required deadline. Ministerial approval was received in July 2022.

20 An early draft IMTP was discussed in detail at a Board development session in February 2022, giving opportunity for Independent Members to contribute. However, this was only a month prior to the submission deadline. The Health Board, therefore, may benefit from involving Independent Members much earlier in the development of future IMTPs to allow time for any substantive changes to be made ahead of submission. This would also give Independent Members more of a role in setting the organisation's strategic direction as set out in Standing Orders (**Recommendation 1**).

Wider planning arrangements

21 We considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders;
- prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans; and
- arrangements for commissioning services are effective and efficient, and aligned to corporate strategies and plans.

22 We found that **the Health Board has good arrangements for developing its plans, with a clear focus on value-based healthcare and commissioned services.**

23 The Health Board has good arrangements in place to oversee the development of its corporate plans. An Integrated Plan Core Group is in place which oversees the development of the IMTP and the underpinning delivery and enabler plans. The process for developing the plans is clearly set out to Board, and oversight is provided by the Executive Committee and the Planning, Partnerships, and Population Committee. The process also sets out clear points of engagement with stakeholders, including staff and the public. As referenced in **paragraph 15**, the 10-year strategy was developed in partnership with stakeholders including Powys County Council, with whom it has a close working relationship. The Health Board is also proactive in ensuring that its corporate plans are developed and set within the strategic context.

24 Value-based healthcare (VBH) is apparent throughout Health Board plans and policies and is recognised as a standalone strategic priority within the IMTP. The Health Board's VBH work is led by the Director of Finance and the Medical Director. This ensures that VBH spans different specialisms within the Health Board, the ownership of the priority reaches across disciplines, and makes it easier to embed VBH corporately. This is evident in the language used by Health Board employees who see value-based healthcare as an essential delivery framework.

25 The Health Board is heavily reliant on commissioned services, and working with other partners to deliver services is a key priority within the IMTP. The Health Board has a well-developed Commissioning Assurance Framework in place which enables the quality and performance of these services to be monitored. The Health Board is also a key partner in several strategic programmes at a regional and national level, such as the Mid Wales Health Collaborative and its role within these arrangements is reflected in the IMTP and 10-year strategy. Some commissioning, however, sits outside of these arrangements, including significant resources allocated to the commissioning of Continuing Health Care (CHC) provision. The Health Board has recognised that there is scope to tighten up commissioning arrangements for CHC provision to ensure better use of resources, as a way of getting greater grip on the CHC financial pressures.

Implementation and monitoring arrangements

26 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board receives regular reports on progress to deliver corporate strategies and plans.

27 We found that **there are clear arrangements for monitoring delivery of the IMTP and supporting plans, but greater focus is needed on measures and impact.**

28 The 2022-25 IMTP is aligned with the Health Board's 10-year strategy. The IMTP sets out clear priorities and actions, including the delivery of supporting plans, and several high-level outcomes. It is supported by a clear Annual Delivery Plan which sets out when the Board can expect the actions and plans to be delivered, the responsible officers, and the route through which it can expect to receive appropriate assurance. The IMTP, however, lacks any detail on how the impact of the actions and the outcomes will be measured, other than reference to the NHS Wales ministerial targets.

29 There are clear arrangements in place for monitoring delivery of the IMTP, although reports could be clearer with a greater focus on measures and impact. Progress on delivery against each of the priorities is reported quarterly to the Delivery and Performance Committee, and the Board. The quarterly delivery reports use a colour coded rating to highlight priorities which are off track. Information within the reports, however, is largely narrative with limited use of data. The reports, therefore, could benefit from being more succinct, with a greater focus on impact and the difference the work is making (**Recommendation 2**).

Governance arrangements

30 In this section of the report, we provide our views on the Health Board's governance arrangements, with a particular focus on:

- key systems of assurance;
- Board and committee effectiveness; and
- the extent to which organisational design supports good governance.

31 Details of progress made on previous year recommendations relating to the Health Board's governance arrangements are provided in **Exhibit 2**.

32 We found that **governance arrangements are generally effective. However, an updated Board Assurance Framework is urgently needed. Staff feedback and Board self-review mechanisms also need to be improved. Instability and capacity within the operational structure remains a risk.**

Systems of assurance

33 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:

- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
- the BAF is underpinned by appropriate systems for managing risks and performance; overseeing the quality and safety of services; and handling information in a secure manner; and

- effective action is taken to address audit and review findings and recommendations.

34 We found that **whilst the Health Board has some effective sources of assurance in place, there is scope to strengthen others, such as the Board Assurance Framework.**

35 The Health Board still does not have an updated BAF in place. We previously reported in 2021 that the BAF had not been updated to reflect the priorities set out in the Health Board's strategy and that the BAF had not been presented to the Board since January 2020. The Health Board had intended to update the BAF by 31 March 2022, but this has still not been done. The lack of an updated BAF is a key gap in ensuring that risks to delivering the Health Board's strategy are clearly identified, that appropriate assurance mapping has taken place to identify and address gaps in assurance, and that controls are in place to mitigate the risks (**Recommendation 3**).

36 Risk management arrangements are in place but these need to be aligned to an updated BAF. The Health Board's Risk Management Framework and Risk Appetite was last updated and approved by the Board in November 2022, following consideration by the Audit, Risk and Assurance Committee (ARAC). The framework states that risks contained in the Corporate Risk Register (CRR) should align to the BAF; however, as previously noted, the BAF is not up to date. The CRR is presented at each Board meeting. Whilst there is little discussion on the CRR itself, the high-risk topics (such as finance) are discussed in depth, and each of the risks are allocated to a committee for oversight. The CRR is considered by the Executive Committee and a 'blank page' exercise has been undertaken through a Board development session to review the corporate risks. In-year amendments have also been made, such as the splitting of the finance risk, recognising the challenges that the Health Board is facing to maintain an in-year break-even position.

37 An Internal Audit review in July 2022 gave reasonable assurance on risk management, noting a need to expand awareness raising and training across all services. Directorate risk registers continue to be spreadsheet based, ahead of the implementation of the Once for Wales system[1]. However, they were not maintained during the pandemic due to the significant operational demands of COVID-19. This has led to a disconnect between directorate risk registers and the CRR. Prior to the pandemic, a Risk and Assurance Group would consider directorate risks and recommend any that needed escalation to the CRR. Although this group has been re-established, it has only met once in July 2022. The Health Board has a desire to improve its risk management arrangements so that it better informs Board activity. An exercise to reassess high risks across directorates and align them to the CRR

[1] The risk module within the Once for Wales Content Management System is due to be deployed across the Health Board in April 2023.

is now needed to ensure any emerging risks at an operational level are on the Board's radar (**Recommendation 4**).

38 The Health Board has robust arrangements for performance management. The revised Integrated Performance Management Framework (IPMF) was approved by the Board in September 2022. The updated IPMF incorporates the Health Board's Commissioning Assurance Framework and covers the period 2022-2026 with an annual review. It also aligns with the NHS Wales performance framework including ministerial priorities. Performance review mechanisms are in place within the IPMF, from personal appraisals through to assurance to Board and its committees. The Integrated Performance Report is comprehensive and presented to the Delivery and Performance Committee and the Board in line with the IMPF. The Delivery and Performance Committee also receives a range of performance data and more localised performance reports and plans.

39 The Health Board's quality governance arrangements are improving since our previous work in 2021[2]. The Health Board developed a Clinical Quality Framework in 2020, which is accompanied by an implementation plan. The Patient Experience, Quality & Safety Committee routinely receives updates on the plan. The latest update shows many areas where progress has been made. However, more work remains in several areas, such as refreshing the patient experience framework, clinical leadership in quality improvement projects, and benchmarking. The Integrated Quality Report to the Patient Experience, Quality & Safety Committee provides a comprehensive overview of quality and safety across the Health Board, including complaints, concerns, and mortality reviews. A comprehensive update on the clinical audit plan is also presented to the committee.

40 The Health Board is making good progress with its information governance arrangements, but some areas remain a concern. In 2021-22, the Health Board repeated its self-assessment against the NHS Information Governance toolkit. The assurance levels across the toolkit's five domains[3] have improved from 2020-21 to the highest level of assurance, except for one domain which has remained the same. Actions to address the shortfalls are set out in an improvement plan which is overseen by the Delivery and Performance Committee. However, records management was not included in the self-assessment submission. In 2019, an Internal Audit report on records management gave a 'no assurance' rating. Progress against recommendations set out in this report has been slow, with outstanding work requiring significant investment to support the digitalisation of records. An update to the Delivery and Performance Committee in June 2022 highlighted that significant progress was still required on five of the six recommendations. The Committee agreed to escalate records management to the

[2] Review of Quality Governance Arrangements, October 2021

[3] The five domains are business responsibilities; business management; individual rights and obligations; technical, physical, and organisational measures; and reporting data breaches.

corporate risk register whilst work is progressing, but at the time of our work, this had not happened.

41 More work is also required to improve the Health Board's cyber security arrangements. An update on the Digital Transformation Programme Plan for 2021-22 to the Delivery and Performance Committee in June 2022 highlighted that the eight tasks dedicated to cyber security improvement were yet to start, despite due dates for completion of March 2022. Areas of improvement were also highlighted in the Cyber Assessment Framework in 2021 to meet Network and Information Systems (NIS) regulations[4]. Since the update report, some improvements have been made such as investments in monitoring platforms and licence upgrades. Cyber security does not routinely feature at Board, but a Board development session is scheduled to discuss cyber security. However, as Board development sessions do not form part of the Health Board's formal assurance processes, it might want to consider holding a closed Board meeting instead to discuss sensitive information.

42 The Health Board has good arrangements in place for tracking audit and review findings and recommendations. In June 2022, Internal Audit gave substantial assurance on the Health Board's arrangements for monitoring and reporting progress in implementing Internal Audit recommendations. A comprehensive update report setting out progress against recommendations relating to internal and external audit, and counter fraud are presented at each ARAC meeting. The report flags the number of recommendations implemented and those that are overdue. To provide additional assurance to the committee, the Health Board could also consider including information which sets out the process for closing recommendations.

Board and committee effectiveness

43 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:

- the Board and its committees demonstrate appropriate levels of public transparency;
- meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
- there is an appropriate and well-functioning committee structure below the Board;

[4] The Network & Information Systems (NIS) Regulations, aimed at raising levels of cyber security and resilience of key systems across the EU, came into force in the UK in May 2018.

- the Board and its committees receive the right information, including views from staff and service users; and
- there is evidence of sufficient self-review by the Board and its committees.

44 We found that **the Board and committees are generally operating well. However, opportunities exist to improve public access to key documents, address gaps in some sources of assurance, strengthen staff feedback, and improve self-review mechanisms.**

45 The Board remains committed to public transparency. Board meetings continue to be held virtually. They are livestreamed, with recordings available to view via the Health Board website shortly after. Meetings are promoted via the website and papers are made publicly available seven days in advance. The amount of business discussed in private sessions is appropriate. All committee meetings also continue to be held virtually. Although they are not livestreamed, members of the public are able to attend by request. However, there is scope to improve transparency further. Unlike other NHS bodies, the Health Board's policies (both clinical and non-clinical) are not available to the public. Although there is reference to them on the Health Board's website, they can only be accessed by those with an NHS Wales account. We have previously recommended the need to improve access to policies on the Health Board's website to enable transparency and accessibility (**Recommendation 5a**).

46 The Health Board's arrangements support the effective conduct of Board and committee business. Standing Orders, Schemes of Delegation, and Standing Financial Instructions were reviewed in May 2022. Updates were made to the delegated director portfolios, the inclusion of the Director of Environment in the Scheme of Delegation, and an additional financial delegation to the Deputy Chief Executive. Meetings consistently follow governance processes, including recording apologies and declarations of interest and reviewing action logs. Minutes of previous meetings are also reviewed, and confirmed minutes are published on the Health Board's website. The use of Chair's actions is also kept to a minimum with only one Chair's action reported in 2022-23 at the time of our review. The Health Board, however, could improve transparency of its register of interests. Although the register is published on the Health Board's website, it can only be accessed by those with an NHS Wales account (**Recommendation 5a**). Standing order schedules available on the Health Board's website are also out of date, with the latest versions uploaded dating back to July 2021. To ensure accurate and up to date information is available and accessible, the Health Board needs to update the online documents to the most recent approved versions (**Recommendation 5b**).

47 The Board and its committees are generally working well. The Board receives assurance reports from each committee, which give an overview of their key business and areas requiring escalation and a wider strategic focus. The timing of committees is kept under review to ensure issues are escalated in a timely manner. Flows of assurances between committees, however, are less clear. At the time of our work, there was no formal mechanism for committee chairs to meet to

discuss relevant issues and share good practice as is the case in other NHS bodies (**Recommendation 6a**). Furthermore, there was no mechanism in place to track actions referred between committees and provide feedback (**Recommendation 6b**). Terms of reference for all committees are up to date and each committee has a lead Executive Director whose portfolio broadly aligns with the committee's focus. Executive Directors make themselves available to the relevant Chair outside of the committees, although this could be more consistent across each committee. There is evidence that committee Chairs are having more input into their workplans and shaping agendas in line with the relevant committee terms of reference which has the potential to lead to slicker more focussed meetings and scrutinised items on a priority basis where required. Once updated, the Health Board should use the BAF to actively inform and shape Board and committee business (**Recommendation 3**).

48 Information presented to the Board and its committees is generally of a good standard, but the presentation and timeliness is variable. Items are presented by Executive Directors or relevant staff members, and questions and comments welcomed. The level of challenge and scrutiny from Independent Members has increased over recent months and this is evident in the meetings we observed. The Health Board has reflected on the quality of reports and the way in which information is presented. Consequently, some Executive Directors now use presentations to focus on areas of concern, which appears to be working well. There is still work required, however, to ensure reporting is being pitched at the correct level and that outcomes and impact are visible. There is also scope to increase the extent to which the sustainable development principle is considered within discussions and decision making. The amount of time spent presenting items could also be reviewed on the assumption that Independent Members will have read papers in advance. This is already happening with lots of items, so applying this good practice widely would ensure more time is spent scrutinising and discussing the topic. Late papers are also still occasionally received which impacts upon the time members have to read and analyse reports ahead of meetings and prepare relevant questions. The Health Board is aware of these issues and is actively reviewing how information is presented.

49 The Health Board continues to demonstrate its commitment to hearing from patients but could do more to hear from staff and wider stakeholders. Patient stories appear regularly at Board, which are well received and provide valuable insight. Patient experience is also a key feature of the Integrated Quality Report presented to the Patient Experience, Quality & Safety Committee. However, as mentioned in **paragraph 39**, more work is needed on the Patient Experience Framework. There are established relationships with the Community Health Council, with regular attendance at Board meetings. The Health Board also engages with a range of third sector and public groups. However, the Board and its committees do not hear from staff and Board walkarounds have not taken place since prior to the pandemic, which is a cause of concern (**Recommendation 7**). Also, the Health Board still does not have a Stakeholder Reference Group and

Healthcare Professionals Forum, despite Standing Order requirements. Whilst the Health Board has other mechanisms for engagement, there are missed opportunities by not having these groups attending Board meetings and contributing to wider strategic discussions (**Recommendation 8**).

50 The Board has stablished after a period of flux, with a diverse portfolio of skills and experience now in place. Turnover at the Board has been handled well. During the year, both a new Chair and Vice-Chair have been appointed, with several other Independent Members appointed. Succession planning arrangements have also been put in place for the ARAC Chair in preparation of the departure of the Independent Member for Finance in early 2023. The Board has a mix of skills and abilities, but at the time of our work, no formal skills assessment had been undertaken to identify specific gaps at Board level. There was recognition, however, that increased financial experience would be needed for the Board given the difficult financial position facing the public sector going forward. A skills review has since commenced.

51 We have previously identified the need to improve induction training for Independent Members. Whilst there has been some improvement, with a central library of resources now developed for new Independent Members, there is still further progress to be made. Independent Members undertake a corporate and national induction as part of their appointment. However, a tailored induction programme relevant to the Health Board's functions and challenges would support members to familiarise themselves more quickly with their roles. The Board continues to make use of development sessions to provide training for members. However, with a new Chair and Vice-Chair now in place, an opportunity exists to explore options for developing a more enhanced development programme which focuses on developing a cohesive Board.

52 The Health Board's arrangements for reviewing Board and committee effectiveness continue to develop. The Health Board undertook a Board effectiveness review in April 2022, which also included a broad review of the committees' following changes made to the committee structure in 2021. The results were considered in a Board development session and arrangements were considered generally effective. Whilst several points for improvement were identified, it is unclear what actions have been taken as a result. The Health Board could benefit from establishing an action planning process following future Board effectiveness reviews which can then be monitored (**Recommendation 9a**). In addition, time is not allocated to review the effectiveness of Board and committee meetings at the end. However, an informal review of committee meetings by the Board Secretary, and relevant committee Chair and Lead Executive has been introduced in the last couple of cycles. Including an item to review meetings on all Board and committee agendas would significantly enhance the Health Board's review arrangements (**Recommendation 9b**).

Organisational design

53 We considered the extent to which the Health Board's organisational structure supports effective governance. In examining this, we have looked at whether:

- the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work; and
- there is clarity on the role of the Board Secretary, and there are adequate resources in place to support the work of the Board and its committees.

54 We found that **despite some new appointments, there remains continual change at an Executive level and disproportionate variances amongst some portfolios. Interim governance arrangements have now been addressed; however, capacity to support the governance function requires attention.**

55 There has been considerable movement of Executive Directors in the last year. This has included:

- Interim arrangements for the Director of Workforce and Organisational Development, and Director of Public Health. The Board Secretary post was also interim during 2022, with a substantive appointment now in place.
- The former Director of Primary Care, Community and Mental Health Services moving to a new Director of Environment post within the Health Board, with the postholder now due to leave in March 2023.
- The former Director of Planning and Performance temporarily moving to the Director of Primary Care, Community and Mental Health Services, and the Deputy Director of Planning and Performance temporarily moving into the director role.
- A new Director of Nursing and Midwifery.

56 There have also been recent changes within the Corporate Governance Team and multiple interim posts are in place at the senior operational level. Whilst activity has remained stable, there is an organisational risk which comes with movement at senior levels, and the number of interim posts implies potentially more change to come. This can cause instability for services and the staff which sit underneath. The Health Board should aim to reduce the number of interim posts to create more stability for both the short- and longer-term **(Recommendation 10)**.

57 Despite the changes and interim arrangements, executive portfolios are clear. There is a good range of Executive Directors, and the Executive Team works well. However, the portfolio of the Director of Primary Care, Community and Mental Health Services is significant. There are deputy roles in place within the structure. However, given the scale of primary and community care services in Powys compared to other health boards, the work required within the portfolio is potentially disproportionate. The Health Board has experienced difficulty in appointing to this role, which potentially impacts continuity of service and embedding strategic direction.

58 The temporary Board Secretary arrangement has provided good support to the Board during the interim period. The Board Secretary role has remained independent and has had clear lines of accountability to the Chair. However, capacity to support the Board Secretary role has been a challenge, with several members of the Corporate Governance Team leaving in early 2022. This is impacting on the ability of some outstanding governance related actions to be addressed. There has been a recent realignment between the governance and corporate business functions to create additional capacity whilst remaining independent. Previously, there was a Head of Risk and Assurance role, but this has now gone. The new Board Secretary will need to consider whether there is sufficient capacity within their team, and whether the realignment is something that needs to be retained.

Exhibit 2: progress made on previous year recommendations.

Recommendation	Description of progress
Healthcare Professionals Forum R2 Standing Orders include a 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 (2018).	**Superseded** Superseded by R8 2022 (see **Exhibit 1**)
Internet Accessibility 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 (2018).	**Superseded** Superseded by R5 2022 (see **Exhibit 1**)
Quality of Board Cover Papers 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	**Completed** The use of Board cover papers has substantially improved.

Recommendation	Description of progress
than just describe the content or purpose of the report (2018).	
Independent member induction 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 (2021).	**Completed** Induction for new Independent Members is now considered an ongoing area of focus.
Associate Board member appointment 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 an 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 (2021).	**Completed** Associate Board Member appointed January 2023
Board and committee agenda papers R3 Board and committee meeting agenda bundles are made available in advance of meetings. However, on occasions some papers are provided late and added to a separate bundle called 'supplementary papers.' Late papers do not allow adequate time for scrutiny, and the use of the term supplementary papers is misleading. The Health Board should ensure as	**Completed** The number of late papers has substantially improved, and supplementary bundles are no longer used.

Recommendation	Description of progress
soon as possible, that appropriate arrangements are in place to: • reduce as far as possible inclusion of late papers; • stop the use of naming late papers 'supplementary;' and • to merge late papers into the main agenda bundle when publishing Board and committee papers on the website (2021).	

Managing financial resources

59 In this section of the report, we provide our views on the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

60 Details of progress made on previous-year recommendations relating to the Health Board's arrangements for managing financial resources are provided in **Exhibit 3**.

61 We found that **the Health Board has a good track record of managing its financial resources. However, it is now facing pressures which means that it is unlikely to meet some of its financial duties for 2022-23. Financial controls have been strengthened to manage this risk. There is good financial reporting, which supports open and transparent oversight and scrutiny.**

Financial objectives

62 We considered the extent to which the Health Board has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Health Board

- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
- has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.

63 We found that **the Health Board met its financial duties for 2021-22. Despite having a balanced financial plan for 2022-23, it is now forecasting a year-end financial deficit which means it will fail to meet some financial duties.**

64 The Health Board met its financial duties for 2021-22, ending the year with a small surplus of £80,000. The Health Board also achieved a revenue break-even position over the three-year period 2019-22 and met its capital resource limit duty with a small surplus of £67,000.

65 The Health Board had a balanced financial plan for 2022-23; however, at Month 4 2022-23, it started reporting a forecast year-end financial deficit of £7.5 million. At Month 10 2022-23, the forecast position remains at £7.5 million. The Health Board's forecast financial deficit will mean that it will fail to meet its revenue financial duties for 2022-23.

66 The Health Board's financial revenue position for 2022-23 is volatile with pressures from CHC costs, costs associated with commissioned activity (particularly by English providers), and variable pay costs. The Health Board has a savings requirement of £4.6 million. Savings are informed by the Health Board's efficiency framework, value-based healthcare principles, and challenge and scrutiny provided through the executive-led investment group to ensure the Health Board's resources are appropriately allocated. However, at Month 10 2022-23, only £0.923 million savings had been delivered, the majority of which related to medicines management. Non-recurrent savings opportunities of £2.27 million have been applied but this has left a shortfall of £1.79 million savings in-year, and £4 million recurrent full-year impact. The non-delivery of recurring savings also poses a risk to the financial position for 2023-24 because of a growing underlying deficit position. The Health Board is on track to achieve its capital resource limit target.

Financial controls

67 We considered the extent to which the Health Board has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:

- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation;
- the Audit Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- there are effective financial management arrangements in place; and
- financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.

68 We found that **the Health Board has appropriate arrangements for financial management and control which have been escalated at an operational level to minimise the impact of financial pressures during the year.**

69 The Health Board has robust arrangements in place to ensure compliance with statutory instruments, and to report breaches. Updated financial control procedures were approved by the ARAC in January 2022, and there are regular reports to the committee on Single Tender Actions (STAs), and losses and special payments.

Only eight STAs were reported between April and December 2022, five of which were prospective STA approvals. Internal Audit gave substantial assurance on the Health Board's budgetary controls, and reasonable assurance on NHS Wales Shared Services Partnership (NWSSP) systems including payroll, accounts payable and primary care contractors. The Health Board has a proactive counter fraud arrangement with cases reported in the public ARAC meeting for transparency.

70 The Health Board is aware of its cost drivers and is taking action to control expenditure. Specific project groups have been established to focus on controlling financial pressures relating to increasing CHC costs, commissioned activity, and nursing variable pay due to vacancies. All groups are reporting to the Executive Committee and providing workable solutions to minimise the impact of the cost pressures. Robust processes are also in place for financial management. Accountability letters have been issued for each directorate from the Chief Executive Officer. They set out the financial requirements, including delivery of savings and improvement opportunities, and a reduction on run rates. Since reporting a forecast deficit, the Health Board has placed itself into financial recovery and established a Performance and Finance Task Group which reports to the Executive Committee. Meetings to monitor the financial position at a directorate level have increased from six-monthly to monthly, and the finance business partner model, which is aligned to the directorates, is supporting the current focus on minimising the financial deficit.

71 The Health Board submitted good quality draft financial statements for audit. There were no significant financial control weaknesses reported in our accounts work which warranted a qualified opinion, although there was some incorrect accounting of several transactions. However, financial control weaknesses were reported in the charitable funds account, with several donated properties not accounted for correctly. We issued a qualified regularity opinion to all health boards due to clinicians' pension tax liabilities.

Monitoring and reporting arrangements

72 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:

- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
- Board members sufficiently challenge ongoing assessments of the financial position.

73 We found that **oversight and scrutiny of the Health Board's financial position has improved with more timely information now reported to Board and relevant committees.**

74 The Health Board has comprehensive financial reports which are presented to both the Board and Delivery and Performance Committee. The report sets out a clear overview of revenue, the forecast position, performance against required savings, commissioned activity, capital spend, and includes the monthly monitoring returns. Detailed information is also provided on the key cost drivers and variances for each of the directorates. The timing of the Delivery and Performance Committee meetings have been adjusted to ensure that the finance information reported is the most recent.

75 The corporate risk relating to the financial position has increased since the Health Board reported a forecast deficit position for 2022-23 and the rolling three-year period. There was detailed and honest reporting at the Delivery and Performance Committee and Board meetings we observed in relation to the financial challenges. The financial position is also closely monitored by the Executive Committee.

Exhibit 3: progress made on previous-year recommendations.

Recommendation	Description of progress
Performance and Resources Committee R1 There are some issues with the functioning of the Performance and Resources Committee[5]. The Committee does not always receive reports on finance and performance for scrutiny before the Board. Finance papers have also been issued after the main set of papers reducing the time available for preparation. Although the Committee's work plan indicates that it will receive reports on savings delivery at each meeting, this is not always the case. The Health Board should: a) review the schedule of meetings to ensure the timing of meetings supports effective detailed scrutiny of finance and performance by Committee; and b) ensure that finance papers are produced and distributed in a timely manner. c) provide reports on the delivery of savings to each meeting to support scrutiny of how the non-delivery of certain schemes will be	**Completed** See **paragraph 75**.

[5] In 2020, the Performance and Resource Committee was changed to become the Delivery and Performance Committee.

Recommendation	Description of progress
mitigated to ensure that the 2019-20 break-even position is delivered (2019).	

Managing the workforce, digital resources, the estate, and other physical assets

76 In this section of the report, we provide our high-level views on the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff well-being (please note we will be undertaking a separate review of the organisation's workforce planning arrangements);
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

77 We found that **the Health Board is supporting staff well-being, recognises the importance of the digital agenda, and has good oversight of the management of its estate. But resources to support digital are an ongoing challenge.**

Supporting staff well-being

78 We considered the extent to which the Health Board has appropriate and effective arrangements in place for supporting staff well-being. In examining this, we have looked at whether:

- mechanisms to seek staff views about their wellbeing needs are effective, and appropriate action is taken to respond to findings; and
- actions to support and improve staff wellbeing are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff well-being during the COVID-19 pandemic[6].

79 We found that **the Health Board has appropriate arrangements in place to support and oversee staff well-being, but more could be done to monitor progress against our previous recommendations.**

80 Staff wellbeing is a clear priority for the Health Board. One of the key priorities within the Health Board's IMTP is to deliver improvements to staff well-being and

[6] Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

engagement. In November 2021, the Health Board adopted its Staff Well-being and Experience Framework. The framework is built around six pillars of staff well-being and engagement with overarching aims to optimise occupational health and develop mechanisms to understand and track staff well-being. These pillars are reflected in the IMTP. At the latest update in November 2022, positive action had been taken in promoting the use of the national tool for well-being conversations, reviewing, and redesigning the occupational health service, and developing and implementing an approach to financial well-being support for staff.

81 The Health Board has sought ways to capture staff feedback. Previously, the Health Board has undertaken staff well-being surveys. For 2022, the Health Board was looking to use the National Staff Survey to seek feedback, but due to this being postponed, a targeted survey process is currently being implemented to get a temperature check of wellbeing in high-risk areas. There is evidence that these surveys are informing Health Board actions. For example, the highest staff sickness levels related to stress and anxiety led to the changes to the occupation health model along with increased capacity. Survey feedback has been used to inform agile working, which is being led by the Director of Environment.

82 There are good arrangements in place for maintaining oversight of staff well-being. In 2021, the Health Board established a Workforce and Culture Committee. Oversight of the relevant workforce priorities within the IMTP, along with the implementation of the Staff Wellbeing and Experience Framework, is the responsibility of this committee with regular updates provided. In December 2021, the ARAC received our Taking Care of the Carers report. A detailed response to our recommendations was subsequently received by the Workforce and Culture Committee in January 2022. However, much of the response contained 'ongoing' action and no further updates on progress have been provided.

Managing digital resources

83 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:

- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
- benefits arising from investments in digital technology are actively monitored by the Board.

84 We found that **the Health Board recognises digital as a key enabler and is developing its digital framework, but the digital infrastructure and availability of funding are significant barriers to delivery.**

85 The COVID-19 pandemic has enabled the Health Board to fast track some its digital ambitions, and it has recently set out its Digital Transformation Plan for the

next three years. This is reflected in the Health Board's IMTP through the 'Digital First' strategic priorities, which cover digital systems, infrastructure, and intelligence. The Digital Transformation Plan was approved by the Board in November 2022, and progress against the plan and delivery against the strategic priorities is monitored through the Delivery and Performance Committee. A Digital Strategic Framework is currently being developed, informed by Board discussions, which will set the framework for the digital transformation and the outcomes that the Health Board expects to achieve.

86 The Health Board, however, is starting from a low base. Whilst the Health Board's digital resources have improved over the two years, recent internal audit and external reviews have provided limited assurance on the Health Board's IT infrastructure, including its Wi-Fi. The Internal Audit report set out seven recommendations, three medium priority and four high priority. Old equipment, network security, limited system monitoring, and switch patching are all aspects which need addressing. The Health Board has an ongoing issue with connectivity due to the rurality of its services, which remains a challenge. The Health Board is also heavily reliant on national solutions. Capital funding for 2022-23 has significant reduced and the Health Board has been unable to allocate any capital funding to digital at a local level.

Managing the estate and other physical assets

87 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

88 We found that **the Health Board has generally good oversight of the management of estates, although visibility and discussion could be improved at Board.**

89 Estates is an integral part of the Health Board's delivery plan, with several IMTP priorities specifically focused on improving the estate. An estates strategy is currently being developed, and clear processes are in place to look at how investment is prioritised, within the constraints of the current capital funding, through an Estates Advisory Funding Board. Several major capital projects are already in place which are fundamental to delivering the strategic aims of the

Health Board. These include the Machynlleth project and the North Powys Wellbeing Campus.

90 There are good arrangements in place to maintain oversight of capital projects and the condition of the estate. The Delivery and Performance Committee receive updates from the Director of Environment on areas of work which are considered by the Innovative Environments Group. This group, in turn, considers information from a range of estates sub-groups. The updates to the committee include a capital programme dashboard and a summary of progress of each of the major capital projects. The updates also include detailed information relating to the condition of the estate, such as fire compliance and backlog maintenance. There is also good coverage of wider aspects relevant to the estate such as the decarbonisation agenda and an agile workforce. Reports from the Director of Environment are clear and informative; however, they are not presented to every committee. Given how integral estates is to the delivery of so much of the short- and long-term plans of the Health Board, it may also be useful to have more visibility and discussion focused on estates at Board.

Appendix 1

Audit methods

Exhibit 4 sets out the approach we adopted for delivering our structured assessment work at the Health Board.

Exhibit 4: audit approach

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following Committees: • Delivery and Performance Committee; • Patient Experience, Quality and Safety Committee; and • Planning, Partnerships and Population Health Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality;

Element of audit approach	Description
	• Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Board Chair; • Vice-Chair; • Chief Executive Officer; • Chair of ARAC; • Interim Director of Planning and Performance; • Director of Finance; and • Interim Board Secretary

Appendix 2

Organisational response to audit recommendations

Exhibit 5: organisational response

Recommendation	Management response	Completion date	Responsible officer
R1 Opportunities exist to engage Independent Members in the early stages of the IMTP planning process to enable the Board to fully discharge its duty to set the strategic direction for the organisation. The Health Board, therefore, should put appropriate arrangements in place to ensure appropriate Independent Member involvement in all IMTP planning stages.	**Recommendation accepted at the point of fieldwork.** For 2023-26 (and therefore 2023-24), Independent Members have been involved in the development of the IMTP 2023-26 via Board Development and briefing sessions over the last 5-6 months culminating in the formal Board meeting in March 2023. This approach has contributed to further strengthening the effectiveness of our unitary board.	Completed	Director for Strategy, Primary Care and Partnerships and Director of Corporate Governance/ Board Secretary

Recommendation	Management response	Completion date	Responsible officer
R2 Delivery reports for monitoring progress against the priorities and actions set out in the IMTP are largely narrative and lack a focus on measures and impact. The Health Board, therefore, should revisit its delivery reports to ensure they are succinct, less narrative, and have an increased focus on measures and impact.	**Recommendation accepted.** Future IMTP monitoring progress reports will include an improved focus on measure and impact. The reference to impact reflects some of the conversation in Executive Committee, Delivery and Performance Committee, and Board. We receive a lot of data and information about performance against targets and work is underway, future IMTP performance reports will be more succinct and focused, including links to further detail should Board members wish to investigate the detail further.	End June 2023	Interim Director of Performance and Commissioning
R3 The Health Board does not have an updated Board Assurance Framework that maps all the opportunities and risks to achieving strategic objectives, identifies gaps in assurance, and informs Board and committee	**Recommendation accepted.** The Board Assurance Framework will be reviewed and updated comprehensively before the 31 March 2024. In the interim, the corporate risk register will be refreshed to reflect the relevant risks for the 2023-24 IMTP and relevant assurances will be mapped into the register.	31 March 2024	Director of Corporate Governance/ Board Secretary

Recommendation		Management response	Completion date	Responsible officer
	workplans. The Health Board, therefore, needs to update its Board Assurance Framework.			
R4	There is currently a disconnect between directorate risk registers and the Corporate Risk Register (CRR). The Health Board, therefore, needs to review all high risks on directorate risk registers to ensure the relevant ones are escalated to the CRR, and that the Board is aware of wider risks that may materialise.	**Recommendation partially accepted.** The corporate risk register (CRR) was refreshed during the summer of 2022 and then updated and reviewed at every Board meeting since then. Each corporate risk is owned by an executive level risk owner; the Executive Committee review the register at least every 2 months. Directorate risk registers are owned by each directorate and relevant risks can be escalated at any time. The CRR is being reviewed in light of the 2022-23 IMTP and risk reviews will take place with each directorate over the summer into Autumn of 2023 (led by Corporate Governance) which will lend further opportunity to ensure directorate to corporate alignment. The Risk and Assurance Group will also recommence from September 2023.	CRR full review – July 2023 Directorate reviews - End Sept 2023 RAG - Sept 2023	Director of Corporate Governance/ Board Secretary
R5	Opportunities exist to improve public access to key Health Board	**Recommendation partially accepted.**		

Recommendation	Management response	Completion date	Responsible officer
documents. The Health Board should ensure that: a) policies and procedures, and the register of interest on the public website are accessible; and b) key documents, including Standing Orders, on the public website are the most recently approved version.	a) Policies and procedures - the Health Board took a decision to provide all documents via the internal intranet to staff. Relevant external policies are available on the website, for example making a complaint (PTR). A review will be undertaken to ensure relevant documents are available to the public via the website. b) Key documents – accepted at the point of fieldwork, all documents have now been updated.	Sept 2023	Director of Corporate Governance / Board Secretary
R6 There are no mechanisms for committee Chairs to meet formally outside of committee meetings to share concerns and good practice, and there are also no mechanisms in place to track issues and actions	**Recommendation accepted.** a) A Committee Chairs forum has been established and met for the first time on the 25 April, and quarterly thereafter. b) The tracking of issues and actions between Committees is now tracked using the new action log	Complete Complete	Director of Corporate Governance / Board Secretary

Recommendation	Management response	Completion date	Responsible officer
referred between committees. The Health Board, therefore, should put in place a mechanism to enable: a) committee chairs to come together on a regular basis; and b) issues and actions referred between committees to be tracked and feedback provided when completed.	template. A feedback mechanism will be incorporated back to relevant committees.		
R7 The Board and its committees do not hear from staff, and Board walkarounds have not been reinstated since the pandemic. The Health Board, therefore, should increase opportunities for Board members to hear from staff. This should include making use of staff stories in Board and committee meetings, and the urgent reinstatement of Board walkarounds.	**Recommendation accepted.** Board walkabouts are actively undertaken by the Chair, Vice Chair, CEO, and other executive directors. It is accepted this needs to be broadened out to the whole Board. An approach will be developed and then implemented from 1 September 2023.	1 September 2023	Director of Corporate Governance / Board Secretary

Recommendation	Management response	Completion date	Responsible officer
R8 Despite Standing Order requirements, the Health Board still does not have a Healthcare Professionals Forum or a Stakeholder Reference Group. The Health Board, therefore, should establish both groups as a matter of urgency.	**Recommendation partially accepted.** The Healthcare Professionals Forum will be reinstated by the 30 September 2023. The Health Board recognises the importance of effective stakeholder engagement, although the Stakeholder Reference Group is not complimentary to our approach to stakeholder engagement and as such will not be reinstated at this time.	30 September 2023	Director of Corporate Governance / Board Secretary
R9 Opportunities exist to improve self-reviews of Board and committee effectiveness. The Health Board, therefore, should: a) ensure areas for improvement are captured and monitored via an action plan; and b) include a standing agenda item in all Board and committee meetings	**Recommendation accepted.** a) Performance reviews were undertaken for the Board and Committees in 2021-22 and currently being undertaken again for 2022-23 – including an opportunity to look ahead into 2023-24. As a point of improvement, an action plan will be developed to ensure implementation and relevant monitoring of agreed actions.	30 June 2023	Director of Corporate Governance / Board Secretary

Recommendation	Management response	Completion date	Responsible officer
to allow for a review of the meeting.	b) Board meeting reviews were introduced from January 2023 and will continue using a variety of means. A mechanism for Committee meeting review will be agreed by the newly formed Chairs Forum for implementation from quarter two.	From 1 July 2023	
R10 The Health Board is carrying several interim posts at a senior level which can cause instability for both services and staff. The Health Board, therefore, should seek to appoint substantively to the interim posts within the Executive team as soon as practical to do so.	**Recommendation acknowledged.** The Health Board fully recognises the need for stable leadership at the senior level. In recent months, a number of substantive appointments have been made which include, the Director of Corporate Governance/Board Secretary, Director for Public Health and Director for Workforce and Organisational Development. Any appointments to interim roles are on a selective basis and to enable the Health Board to respond to specific challenges and circumstances.	N/A – considered complete	Director of Workforce & Organisational Development

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8

Audit Risk and Assurance Committee	**Date of Meeting: 16th May 2023**
Subject:	**Counter Fraud Annual Report 2022/23**
Approved and Presented by:	Director of Finance and IT / Matthew Evans Head of Counter Fraud
Prepared by:	Head of Counter Fraud
Other Committees and meetings considered at:	N/A

PURPOSE:

The Counter Fraud Annual Report 2022/23 is presented to the Audit Risk & Assurance Committee to inform of counter fraud performance during the last reporting period. The Report is written in line with the requirements of the NHS Counter Fraud Standards and Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements.

Accompanying the Annual Report is the draft Functional Standard Return submission. This is a review of performance against NHS Counter Fraud Standards and a self-review submission is a requirement on an annual basis.

RECOMMENDATION(S):

It is recommended that the Audit Risk & Assurance Committee note the contents of the Counter Fraud Annual Report 2022/23 as presented and take assurance from the work outlined that has taken place throughout the year.

The appended draft Functional Standard Return 2022/23 requires approval by the Chair of the Audit Risk & Assurance Committee; deadline for submission is 31 May 2023. It is recommended that opportunity to discuss and inform Chair approval is undertaken at this meeting.

Ratification	Discussion	Information
	X	X

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

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				

Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				

Risk Assessment:

	Level of risk identified			
	None	**Low**	**Moderate**	**High**
Clinical	✓			
Financial	✓			
Corporate	✓			
Operational	✓			
Reputational	✓			

Powys Teaching Health Board

Counter Fraud Annual Report 2022/23

Matthew Evans

Table of contents

1. Introduction

This report has been written in accordance with the provisions of the Fraud, Bribery and Corruption Standards for NHS Wales Bodies (the Functional Standards) which require Local Counter Fraud Specialists (LCFS) to provide a written annual report reflecting the counter fraud, bribery and corruption (economic crime) work undertaken during the financial year.

The Counter Fraud Work Plan for 2022/23 was approved by the Audit Committee in April 2022 and identified a total resource of 308 days for the year. The Counter Fraud Team delivered 308 days of counter fraud activity. The total cost for the provision of local counter fraud services for the year was £73,204.

For ease of reference and in line with the Work Plan, this report is structured under in line with Functional Standards Requirements of Counter Fraud activity. The annual report should be completed in enough detail to enable the responsible officers within the organisation to gain sufficient assurance that the counter fraud, bribery and corruption work undertaken is compliant with the Functional Standard Requirements and has been completed in line with organisations counter fraud workplan.

When the required work has not been completed against the counter fraud work plan or is not fully compliant with the Functional Standard Requirements details of the corrective actions to be undertaken should be reported.

2. Executive summary of organisational compliance

The Functional Standards require each health body to produce a written work plan outlining the LCFS' projected duties for the year. The 2022/23 work plan, agreed by both the Director of Finance and Audit Committee, took due account of the work required to ensure consistent and effective implementation and delivery of the newly introduced Functional Standards. It was designed to ensure a holistic risk-based approach to counter fraud work within the Health Board with work split between proactive and reactive counter fraud activity. Flexibility contained in the work plan allowed high risk work to be undertaken urgently and dynamically.

Progress against the plan has been monitored during meetings with the Director of Finance, with update reports produced and presented to the Audit Committee in line with its agreed work programme.

The Counter Fraud Team continue to attend meetings and forums organised by the NHS Counter Fraud Service (CFS) Wales. These meetings provide an invaluable opportunity to share information and identify emerging risks, themes and areas of best practice with NHS Counter Fraud colleagues across Wales. They have also been utilised by the NHS Counter Fraud Authority Training Delivery Leads to deliver key skills development sessions, refreshing fundamental operational skills and providing information and training on any relevant new economic crime matters or legislation.

As part of the quality assurance process, NHS organisations in Wales are required to complete a self-review of their progress in implementing the Standards. From 2021/22 NHS Wales adopted the Government Functional Standards on Counter Fraud (NHS Requirements) to replace NHS Counter Fraud Authority's (NHS CFA) 'NHS Counter Fraud Standards (Wales)'. Counter Fraud work since that introduction has been focussed on building or maintaining compliance with the new standards. Since 2021/22 the Health Board has shown continual annual improvement in ratings against the Standards or maintained ratings.

There are two Standards Components that remain below Green rated however; Component 1B - Accountable individual - rated Amber and Component 3 - Fraud bribery and corruption risk assessment - rated Amber.

Component 1B – Accountable Individual

This Standard is currently rated Amber due to the Health Board only recently nominating a Fraud Champion to the role. The Health Board's Director of Corporate Governance was identified as the most suitable Senior Officer to meet the requirements of the Fraud Champion role and a nomination was subsequently completed. An action plan has been set for Fraud Champion activity for 2023/24 which includes support in enabling managing fraud risks via the existing Health Board mechanisms, providing strategic support around our reporting of counter fraud work, and communications around gifts and hospitality/declarations of interests. This activity will result in Green rating within next review.

Component 3 - Fraud Bribery and Corruption Risk Assessment

This Component is currently rated as Amber due to the requirements for maturity of this area of work to enable demonstration of continuous monitoring of fraud risk at a senior level, evidence of subsequent risk mitigation and that review of resources has been undertaken to ensure levels are suitable for this purpose.

Since introduction of this Component the Counter Fraud Team have sought to establish the fraud risk assessment processes aligned to the Health Board's existing Risk Management procedures.

The Team have then created a core fraud risk profile developed from 129 NHS fraud risk descriptors. Alongside this further scanning has been undertaken to capture and manage emerging fraud risks such as arising from investigation, Fraud Prevention Notices, local intelligence, audit reports and findings, and NHS CFA IBURN releases. A tracker has been created to track and manage the actions around these known and emerging fraud risks.

LCFSs have subsequently sought to undertake comprehensive risk assessments in liaison with local risk owners to establish a core foundation of assessments to work from. Arrangements have been made to record those risks on the DATIX system which will be utilised from 2023/24 to manage, track and measure fraud risk within the Health Board.

Use of the DATIX system, alongside the local tracker, will allow evidence to be developed to meet the remaining elements outstanding to uplift this Component to Green.

3. Declaration of compliance against the Functional Standard Requirements at the end of March 2022

The annual report must contain one of the declarations listed below. This declaration must reflect the organisation type and be signed by the Accountable Board Member in order for the organisation to be compliant with the Functional Standard Requirements.

Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2022-23 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption, and that the above rating has been achieved.

Organisation	**Powys Teaching Health Board**
Accountable Board Member Signature	
Date	

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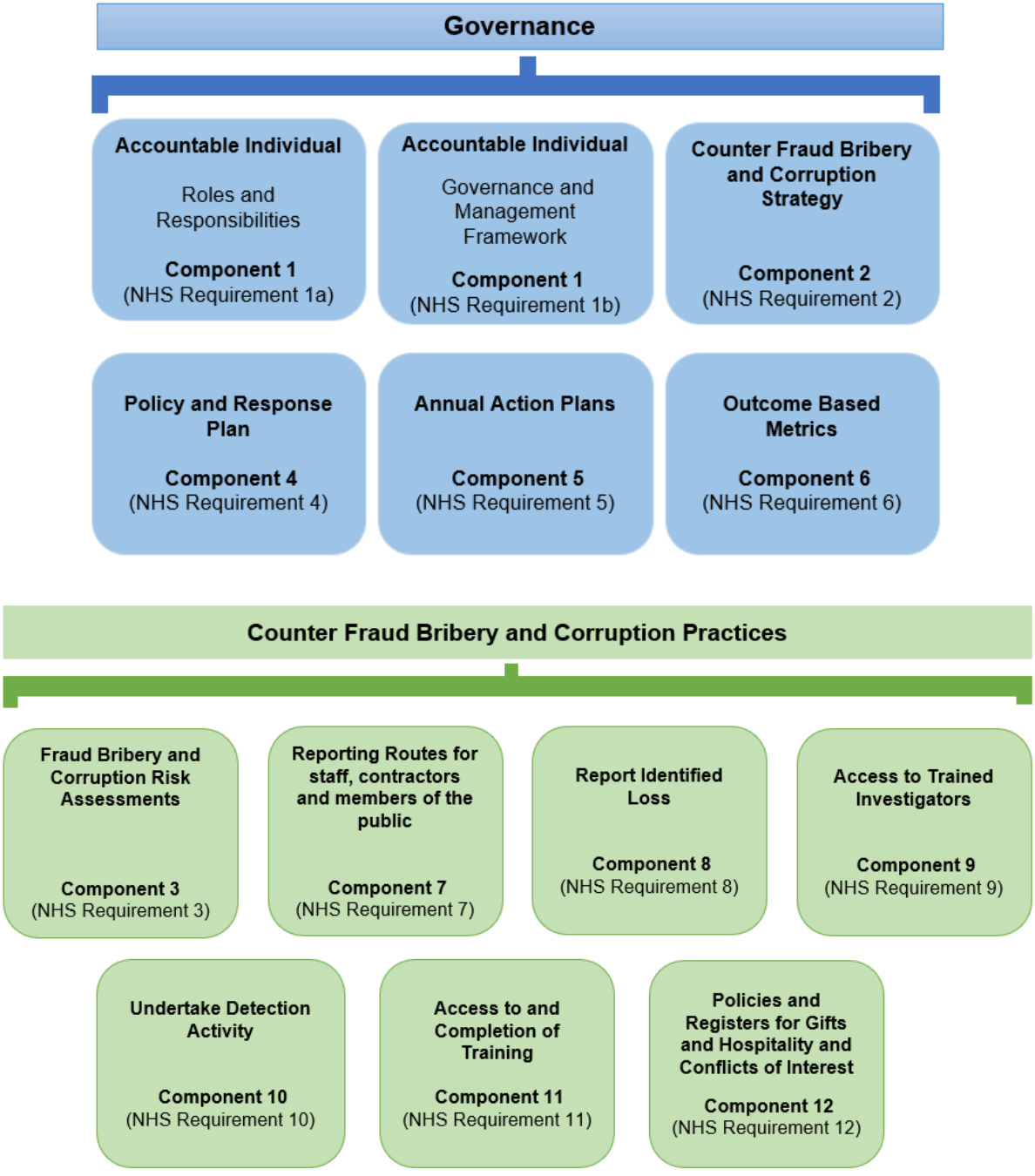
12/05/2023 15:46:31

4. Work carried out against the Functional Standard Requirements



Governance

This section of the annual report outlines how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption.

Work relating to each Governance Component of the Functional Standard is summarised and current and previous rating for each Requirement is set out below.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 1 **Accountable individual**	**NHS Requirement 1A**	This relates to the role of the accountable board member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.	GREEN	GREEN	The Director of Finance is responsible for the strategic management and support of counter fraud work. A good level of support and assistance is given to the Counter Fraud Team in the discharge of responsibilities by the Director of Finance and the wider Finance Directorate. The Health Board's Audit Committee receive regular reports of Counter Fraud activity throughout the year which includes quarterly benchmarking reports. The Audit Committee receive and approve the Health Board's Counter Fraud Annual Report and Workplan. All Counter Fraud submissions to the Audit Committee are sponsored and supported by the Director of Finance.
	NHS Requirement 1B	This relates to the work of the organisations board / governing body in	GREEN	AMBER	NHSCFA proactive exercise reports have been presented to the Health Board's Audit

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
		gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.			Committee. A concluding report Quality & Assurance evaluation has also been presented to Audit Committee which highlighted work undertaken in response to findings. The Audit Committee receives an Annual Report written in line with NHSCFA guidance using the template. This includes details of the Functional Standard Return for review. The Health Board has a nominated Fraud Champion. However this nomination has only been confirmed recently and as such no opportunity to undertake activity to discharge duties. Work planned for the Fraud Champion in 2023/24 includes support in enabling managing fraud risks via the existing Health Board mechanisms, providing strategic support around our reporting of counter fraud work, and communications around gifts and hospitality/declarations of interests. This activity will result in Green rating within next review.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 2 **Counter fraud bribery and corruption strategy**	**NHS Requirement 2**	This Component relates to the organisations over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.	GREEN	GREEN	The Health Board's Counter Fraud Policy & Response Plan includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery and corruption strategy. A counter fraud work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks The CFP&RP and work plan are agreed by Director of Finance and Audit Committee and progress is tracked via regular reporting and attendance at Audit Committee.
Component 4 **Policy and response plan** Patterson,Liz 12/05/2023 15:46:31	**NHS Requirement 4**	This Component relates to the organisations counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	GREEN	GREEN	The Health Board has a Counter Fraud Policy & Response Plan in place. The Policy is reviewed to ensure that it remains current. A full review was undertaken in November 2022. Issues relating to bribery and fraud are also referenced within the Standards of Behaviour Policy.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					Staff awareness of these key policy documents is measured using questionnaires and a survey issued in March 2022. Further surveys were undertaken on a targeted basis in November 2022.
Component 5 **Annual Action Plan**	**NHS Requirement 5**	This Component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.	GREEN	GREEN	A counter fraud work plan is developed in line with key objectives of the strategy and alignment to national standards. Resource is allocated in line with this within the context of 4 strategic areas of counter fraud activity; Inform and involve, prevent and deter, hold to account and strategic governance. Progress against this work plan is monitored and evaluated through out the year with regular meetings with Director of Finance and regular reporting to Audit Committee. Allocated resource is included as part of this regular reporting along with benchmarking of overall resource availability.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 6 **Outcome based metrics**	**NHS Requirement 6**	This Component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance	GREEN	GREEN	All Wales Performance statistics are collated on a quarterly basis and shared between Health Boards and Welsh Government. Statistics are utilised to examine performance between NHS Wales organisations. Benchmarking undertaken on an organisational level against previous years and against other NHS Wales Organisations. Reports on performance and benchmarking are shared with the Audit Committee to scrutinise. Clue3 includes recording and reporting mechanisms for proactive and reactive outcomes of counter fraud work which is utilised as a recording mechanism.

Counter Fraud Bribery and Corruption Practices

This section of the annual report outlines the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The organisation should report against each Counter Fraud Practice Component, under the Functional Standard and summarise the work completed to meet each Requirement. A high-level summary of each of the Counter Fraud Practice Components is set out below.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 3 **Fraud bribery and corruption risk assessment**	**NHS Requirement 3**	This Component relates to the local risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisations counter fraud, bribery and corruption provision is proportionate to the level of risk identified.	AMBER	AMBER	Comprehensive risk assessments are carried out in line with the GCFP methodology and recording aligns to the Health Board's Risk Management Policy. The annual counter fraud work is informed by these risk assessments. NHS CFA issued national fraud risks guidance containing 129 fraud risk descriptors across the entirety of business areas the NHS engages in. These risks have been concatenated into core risk areas for review locally. Work since introduction of this Component has been to map fraud risk descriptors to core risk assessments, development of a fraud risk profile around core risk areas, implementation of managing fraud risk via DATIX, implement sufficient scanning techniques and processes to ensure all emerging fraud risk is captured and reviewed against existing fraud risk assessments. Action plan to lift rating to Green is to utilise results of previous work to effectively demonstrate monitoring of risk with measurable outcomes.

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
Component 7 **Reporting routes for staff, contractors and members of the public**	**NHS Requirement 7**	This Component relates to the reporting routes in place at the organisations to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS fraud case management system.	GREEN	GREEN	The Health Board has well documented reporting routes for any party to report incidents of fraud, bribery and corruption. Reporting routes are formalised in the Counter Fraud Policy & Response Plan and Bribery Policy. Reporting routes are also highlighted within counter fraud awareness training, newsletters and communications, included on the Counter Fraud Intranet pages and highlighted in the Counter Fraud Information Booklet available for staff. Reporting routes include a central Counter Fraud email inbox, email and phone directly to LCFSs, a Microsoft Forms Fraud Reporting form, the National Fraud and Corruption Reporting Line as well as alternative reporting routes to Director of Finance and whistleblowing charity Protect-Public Concern at Work. The Counter Fraud Team have regularly received contact from individuals raising concerns resulting in the commencement of 12 new investigations in 2022/23. Surveys have been undertaken

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					in March and November 2022 to measure effectiveness.
Component 8 **Report identified loss**	**NHS Requirement 8**	This Component relates to the organisations use of the approved NHS fraud case management system to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	GREEN	The Health Board fully utilises the Clue case management system to record and report identified loss. The system includes opportunity to record all investigaiton materials, local proactive exercises and operational statistical information. Statistics are collated and submitted on a quarterly basis to Counter Fraud Service Wales and an All Wales Operational Performance report produced. A benchmarking report utilising this information is presented to Audit Committee on a quarterly basis.
Component 9 **Access to trained investigators**	**NHS Requirement 9**	This Component relates to the accredited Local Counter Fraud Specialist (LCFS) at the organisation, and details of the continuous professional	GREEN	GREEN	Local Counter Fraud Services for the Health Board are provided by Swansea Bay UHB under a Service Level Agreement. The service is delivered by qualified, nominated and accredited LCFS,

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
		development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.			who conduct the full range of anti-fraud, bribery and corruption work on behalf of the organisation. The LCFS attend all necessary training and continuous professional development events as required to appropriately fulfil their role on an ongoing basis. The counter fraud accredited resource for 2022/23 was 2.6 FTE.
Component 10 **Undertake detection activity**	**NHS Requirement 10**	This Component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.	GREEN	GREEN	LCFS review Final Internal and External Audit reports and meet with the Head of Internal Audit to share details on identified risk. This would include instances where data mining or sampling has highlighted outliers or concerns. A PPV programme is undertaken in respect of GPs, Opticians and Pharmacies, with final reports received by the LCFS. Meetings are held with the PPV Manager. The HB also participates in the NFI process. Risk assessments are considered as part of this work and completed where necessary. As a result of this information and intelligence review

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					process the Counter Fraud Team have registered 3 local proactive exercises on the case management system in 2022/23.
Component 11 **Access to and completion of training** Patterson,Liz 12/05/2023 15:46:31	**NHS Requirement 11**	This Component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.	GREEN	GREEN	The Health Board has an ongoing programme of work to raise awareness of economic crime issues amongst all staff, using a range of methods including virtually delivered presentations and e-learning package availability. This is supported by newsletters and intranet pages alongside the regular release of counter fraud information via articles and alerts. The awareness programme is sufficient to achieve a Green rating but is an area highlighted for improvement. Work has been undertaken including risk based training resulting from proactive work, roll out of training to new areas such as GMS Contractors, targeting of high volume groups of staff following reintroduction of such meetings following

Function Standard Component	NHS Requirement		2022 Rating	2023 Rating	Current Position
					Covid, refresh of existing communication methods such as the counter fraud intranet pages and introduction of short form counter fraud awareness articles. Contact with the Counter Fraud Team has increased as a result but this remains an area to seek continued improvement despite Green rating.
Component 12 **Policies and registers for gifts and hospitality and Conflicts of Interest**	**NHS Requirement 12**	This Component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of which is regularly tested.	GREEN	GREEN	The HB has a Standards of Behaviour Policy in place, which has incorporated declarations of interest, gifts, hospitality and sponsorship. The Policy also includes reference to fraud, bribery and corruption and the requirements of the Bribery Act 2010, and is available to all staff via the intranet. It is also promoted during fraud awareness presentations. Testing of staff awareness of the Policy has been included in surveys issued in March and November 2022.

5. Appendices

Appendix 1 – Counter Fraud Activity

This section of the annual report should detail the total counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Area of activity	Days used
Proactive work	202
Reactive work	106
Total days used	308

Appendix 2 – Counter Fraud Costs

This section of the annual report should detail the total costs of the counter fraud resources used by the organisation. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B.

Cost of Counter Fraud, Bribery and Corruption Work	Total Costs £
Proactive costs	£48010
Reactive costs	£25194
Total costs	£73204

Appendix 3 – Nominations Overview

This section of the annual report should detail the nominated officers at the organisation during the reporting period, including all supporting LCFS. If any of the nominations have changed during the year, the date of the change should be included.

The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B and 9.

Role	Name of Nominated Person
Accountable Board Member	Pete Hopgood
Audit Committee Chair	Mark Taylor
Fraud Champion	Helen Bushell
Lead LCFS	Matthew Evans
Supporting LCFS	Vacant

Appendix 4 – Investigation Information

This section of the annual report should detail all the activity recorded on the CLUE Case Management System. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6, 7 and 8.

Investigation Information	Number
Investigations carried forward from 2020/21	3
Investigations Opened during the period	12
Investigations Closed during period	10
Investigations Ongoing	5

Appendix 5 – Risk Based Exercises

This section of the annual report should detail all the Fraud Risk Assessments (FRAs), Local Proactive Exercises (LPEs) and System Weakness Reports (SWRs) undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the NHS Counter Functional Standard NHS Requirement 1B, 3, 5, 6, 8 and 10.

Fraud Risk Assessments	Number
Number of FRAs reviewed in line with the organisations risk management policy	4

Local Proactive Exercises	Number
Number of LPEs conducted during the year	4
Number of LPEs recorded on the NHS CFA Case management system as per component 8	1
Number of LPEs concluded during the year	0

System Weakness Reports	Number
Number of SWRs identified during the year	0
Number of SWRs concluded during the year on the NHS CFA Case management system as per component 8	0
Number of new processes adapted or introduced as a result of SWRs	0

Appendix 6 - Sanction & Redress Overview

This section of the annual report should detail of any sanctions and redress activity undertaken. The following information must be included in the counter fraud annual report in order for the organisation to be compliant with the Functional Standard NHS Requirement 1B, 6 and 8.

Sanction Imposed	Number
Disciplinary	0
Civil	2
Criminal	0
Total Sanctions	2

Redress Imposed	Total Amount £
Fraud identified	£17,394
Fraud Prevented	£17,394
Fraud Recovered	£17,394

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.9

Audit, Risk and Assurance Committee	**DATE OF MEETING: 16th May 2023**
Subject:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS**
Approved and presented by:	Director of Corporate Governance/Board Secretary
Prepared by:	Interim Corporate Governance Business Officer Interim Corporate Governance Manager
Other Committees and meetings considered at:	Executive Committee 19th April 2023

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 31st March 2023.

RECOMMENDATION(S):

The Audit Committee is asked to CONSIDER the current position of outstanding Audit Recommendations and take ASSURANCE that the organisation has an appropriate system for tracking and responding to audit recommendations.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

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

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

BACKGROUND AND ASSESSMENT:

INTERNAL AUDIT

During 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	1	6	6	13
Priority 2	0	0	6	Medium	2	8	4	20
Priority 3	0	0	3	Low	1	1	1	6
Not Yet Prioritised	0	0	0					0
TOTAL	**0**	**0**	**9**		**4**	**15**	**11**	**39**

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.

EXTERNAL AUDIT

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

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

Detail of re-prioritised external audit recommendations can be found appended to this report as follows: -
Appendix G – External Audit Recommendations that remain OUTSTANDING.
Appendix H - External Audit Recommendations Not Yet Due for Implementation**.**
Appendix I – External Audit Recommendations COMPLETED since the previous report.

LOCAL COUNTER FRAUD SERVICES

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

NEXT STEPS:

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

From April 2023, an assessment of each Directorates position in relation to the implementation of Audit Recommendations will be integrated into the Directorate Review process, Directorate Reviews are held twice yearly (Apr/May and Oct/Nov) and are led by the Chief Executive.

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	0	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	2	3	1								✓
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**	**20**	**57**	**31**	**3**	**6**	**1**	**0**	**4**	**4**	**0**	

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	2	1	1	1	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	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**	**4**	**24**	**24**	**1**	**2**	**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	1	0	1	2	3	0	0	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	2	1	0	0	0	×
212207	Dementia Services Home Treatment Teams	Reasonable	1	4	1	0	3	1	1	1	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	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	3	3	0	2	3	0	1	0	0	0	0	0	×
212216	Risk Management and Assurance	Reasonable	0	4	1	0	4	1							✓
212217	Breathe Well Programme	Substantial	0	3	1	0	3	1							✓
212218	Recommendation Tracking Process & Follow Up Review	Substantial	0	0	2	0	0	2							✓
TOTAL			**15**	**46**	**13**	**9**	**38**	**12**	**6**	**8**	**1**	**0**	**0**	**0**	

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	2	0	4	1	0	4	3	0	×
222303	Security Services	Reasonable	1	5	0	0	4	0	1	0	0	0	1	0	×
222304	Staff Rostering	Reasonable	0	2	0	0	2	0							✓
222305	Control of Contractors	Substantial	0	1	0	0	1	0							✓
222306	Decarbonisation	Not Rated	0	0	3	0	0	1	0	0	0	0	0	2	×
222307	Looked After Children Health Assessments	Substantial	0	1	0	0	0	0	0	1	0	0	0	0	×
222308	Cancer Services -Access to Symptomatic FIT	Substantial	0	1	1	0	1	1							✓
222309	Women's and Children's Services	Substantial	0	0	2	0	0	2							✓
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	0	2	1	0	1	1	0	1	0	0	0	0	×
222311	North Powys Wellbeing Programme	Reasonable	2	3	2	2	1	1	0	1	1	0	1	0	×
222312	Charitable Funds	Reasonable	0	1	2	0	1	2							✓
222313	Workforce Futures	Reasonable	0	2	2	0	2	2							✓
222314	Welsh Language Standards	Limited	5	3	0	4	3	0	1	0	0	0	0	0	×
222315	Therapies and Health Science Professional Governance Structure	Reasonable	0	3	1	0	0	0	0	0	0	0	3	1	×
222316	Incident Management	Reasonable	1	3	1	0	0	0	0	0	0	1	3	1	×
222317	Cyber Security	Limited	2	1	0	0	0	0	0	0	0	2	1	0	×
TOTAL			**15**	**31**	**15**	**6**	**18**	**10**	**6**	**4**	**1**	**7**	**12**	**4**	

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	11	1	0	1	0	×
181952	Clinical coding follow-up review	4	4					✓
181953	Audit of Financial Statements Report	4	4					✓
TOTAL		**20**	**19**	**1**	**0**	**1**	**0**	

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	10	1	0	1	0	0	0	×
202153	Audit of Accounts	6	6							✓
TOTAL		**20**	**19**	**1**	**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	3							✓
212253	Audit of Accounts Report - Charitable Funds and Other Related Charities	3	2	1	0	0	0	1	0	×
TOTAL		**6**	**5**	**1**	**0**	**0**	**0**	**1**	**0**	

2022/23 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		
222301	Reviewing Public Bodies' current approach for conducting	1	0	0	0	0	0	0	1	×
222302	The National Fraud initiative in Wales 2020-21	3	0	1	0	0	0	0	2	×
222303	Review of the Strategic Renewal Portfolio	5	4	1	0	0	0	0	0	×
TOTAL		**9**	**4**	**1**	**0**	**0**	**0**	**0**	**3**	

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**	

ITEM 3.9i APPENDIX D - AUDIT RECOMMENDATIONS THAT REMAIN OUTSTANDING

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please provide	Progress being made to implement recommendation				If action is complete, can evidence be provided 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	How is the risk identified being mitigated pending	When will implementation be achieved?					
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	Overdue	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. Business case presented to IBG, funding is still to be secured. Storage of records is identified however requires further funding to address weakness in storage facilities identified. Resource to be prioritised to categorise records within service areas so that destrcution of records where applicable can commence 11/04/23 All storage sites have been identified. Any new requests for records storage are submitted and approved by the Property and Accommodation Group. Embargo on the destruction of records has been lifted, planning underway led by IG to ensure all records over their retention period are destroyed. Remaining records will be appraised and stored appropriately. For offsite and un-manned locations registers are kept of the records held by service, age and type. Any records related risks are logged on local and IG risk registers. In line with NHS Wales NHS Records Management Code of Practice 2022, attention has been brought to a 20-year retention ruling that applies to patients with long term illnesses. Senior level discussions are taking place in terms of how the health board commences the destruction programme and the following actions are being undertaken: · How to identify these cohort of patients. · What is the definition of a long-term condition and the complexities that this will bring to the process.	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed request extension to 31/12/22		25	3	Mar-23	14/11/2019
192006	Records Management	No Assurance	Director of Finance, Information and IT		R5	Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan: • Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records. • Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records.	Apr-22	Dec-22	Overdue	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. Business case presented to IBG, funding is still to be secured. Storage of records is identified however requires further funding to address weakness in storage facilities identified. Resource to be prioritised to categorise records within service areas so that destrcution of records where applicable can commence 11/04/23 A Business case for the Digitisation of Records Project was submitted to the Investments Benefit Group in January 2023 and approved. It was then shared with the executive group for sign off. Due to the high capital costs, investment has been sought from Welsh Government to fund the proposal for 2 years. The decision outcome is waiting to be shared. If this funding is not forthcoming from WG our action plan will need to be reviewed and we will need to be clear on what can be achieved with the current level of resources available by prioritisation	COVID-19 If Funding is not approved at IBG in August 2022. Previously suggested Records Management Improvement Group will form part of the Digitisation Project Board once established	A Records Management Project Risk Register has been developed. Risks has been identified as part of the case and will form part of the project plan which will be managed and overseen by the project board.	Business Cases for digitisation of active (April 21) and archive (April 22) records to be developed Request this is closed as actions will be captured now via the PM and Records Manager project plan and SIP and covered in the action line above		25	3	Mar-23	14/11/2019
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Planning & Performance Director of Finance and IT & Director of Primary, Community and Mental Health Services Director of Nursing	R2	2.1 The health board should agree a common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement. This is an action set out within the S33 agreement for delivery by PTHB & PCC. 2.2 The health board should review its Scheme of Delegation for CHC packages (Section 12) to ensure that CHC expenditure is subject to an appropriate level of scrutiny by appropriate individuals within the organisation for both Adult and MH&LD CHC. 2.3 The CHC Standard Operating Procedures should be aligned with the Scheme of Delegation (Section 12) and practices in Adult and MH&LD CHC should be aligned. The CHC SOP should also be updated to clarify when contract renewals valued over £50,000 p.a. should go through a High Cost Resource Panel. 2.4 The health board should ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for CHC packages across Adult and Mental Health Nursing.	2.1 A common contract and specification for CHC care home contracts not covered by the All Wales Framework Agreement to be developed, as set out within the S33 agreement for delivery by PTHB & PCC. 2.2 There is currently a national review being undertaken for Wales of Health Board Scheme of Delegation and Reservation of Powers lead by a small Task & Finish Group chaired by Welsh Government. The outcome of this Task & Finish Group may require a larger review for the health board. The work is planned to be 3-6 months long and commenced in early November 2019. Once the recommendations and/or revised Scheme of Delegation is issued the health board will undertake a review focusing on the recommendations of this report 2.3 CHC Standard Operating Procedure to be updated to ensure the all cases over £50,000 are referred to High Cost Panel 2.4 Formal communication to be issued from the Director of Finance to services leads for CHC (Adult and Mental Health) on the need to ensure the Scheme of Delegation (Section 12) and CHC Standard Operating Procedures are adhered to for all CHC packages. Additionally, to offer support if clarity is required on the Scheme of Delegation or SOP.	Dec-20	Sep-21	Overdue	2	Partially complete		2.2 We have reviewed the scheme of delegation within PTHB Schemes of Delegation work and the revised SFIs have been issued to Health Board in draft. These will then need to be finalised and taken through the Board for ratification and once agreed a check will need to be undertaken to ensure all areas of the HB are in line with these updated overarching procedures. With regard to the process for approving CHC packages revised documentation has been drafted which clarifies the approval levels and processes required. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of contracts, Standard Operating Procedures and Scheme of Delegation. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 Complex Care Project has commenced with Secondment to lead the work and review the requirements in line with the New Framework which is being implemented. Scheme of delegation and sign off procedures are in place and effective. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. 02.02.2023 - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for future working. 06/04/23 - DDoN and AD Community Services developing a report to include recommendations for the future. Ongoing improvements being made to processes through the CHC Delivery Group	Delay in Lead Clinician for the complex care project to commence. Delay in CHC Framework starting	Completed local review of scheme of delegation and sign off procedures in December 20221 as aprt of the D2RA pathway implementation	Sep-21		27	18	Mar-23	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing & Director of Planning & Performance	R3	Out-of-county care homes monitoring 3.1 The health board should consider strengthening its out-of-county care home governance/monitoring arrangements. For example, guidance could be provided to CCSNs on the wider governance considerations required in the form of a checklist and incorporated into the current individual review forms. The arrangements should mirror the joint monitoring process and include proactive consideration of recent inspectorate visits and feedback from the relevant local authority. 3.2 This process should be documented in the CHC SOP (see finding 4 also). In-county care homes monitoring 3.3 The health board should clarify how it receives assurance that the LA has escalated issues identified through the joint monitoring process to the JQAP as appropriate, for example through its representation at the JIMP and JQAP meetings and through feedback to the CCSG. 3.4 The health board's CHC SOP should be updated to make reference to the joint monitoring process under the S33 agreement, including the assurance it receives as per 3.3 (see finding 4 also). 3.5 The above recommendations on in- and out-of-county care homes monitoring should take into consideration the NHS Wales National Collaborative Commissioning Unit project on provider care map dashboards. 3.6 The assurance mechanisms over CHC and FNC packages, including for monitoring both in- and out-of-county care homes, should be incorporated into the Board Assurance Framework. Funded Nursing Care	3.1 Update the current checklist used for Joint Monitoring Visits for use when reviewing 'Out of County' patients to capture wider governance arrangements and patient experience. 3.2 Update SOP to incorporate the process. 3.3 Minutes following JIMP to be shared at the CCSG. 3.4 CHC SOP to be updated to make reference to the joint monitoring process under the S33 agreement. 3.5 As above	Apr-20	Jul-21	Overdue	2	Partially complete		3.1 Yes this will form part of out of county reviews. A form has been developed but it has not been used as of yet. To support this action, it needs agreement from all services (MH LD and adult) as a way forward. 3.2 It has not been updated in the CHC SOP but it needs it's own SOP to support our governance arrangements. Al, I have looked at this, this week and I'm trying to put time aside to complete. 3.3 This action can be closed 3.4 This is not completed 3.5 Yes we have the BI dashboard, however, there is ongoing work to develop the dashboard further dashboard further. 3.7 & 3.8 There is now a section 33 manager that oversees this function. The CCSN team have also developed a flow chart for ensuring payment is made. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of checklists, quality dashboard and SOPs. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 Escalation of care homes is supporrted via the local Care Home MDT. Assurance checkes part of the QA assessment for out of county placements in place. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. 02.02.2023 - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for futrure working.	COVID19 has restricted Monitoring visits	Monitoring is not completed jointly with PCC but will be undertaken when there is a review within that care home. Revised oversight process established during COVID-19, lessons learned will be used to reshape structure feeding into Section 33 arrangements.	Jul-21		35	20	Mar-23	
192014	Care Homes Governance	Limited	Director of Nursing & Midwifery	Director of Nursing / Director of Primary, Community and Mental Health Services	R4	4.1 The CHC SOP should be updated to reflect: • the care homes S33 agreement, pooled fund and joint care homes monitoring process; • the national reviews (UK and Welsh Government) of the National Framework and CHC/FNC working practices; • the process within both Adult and MH&LD CHC, aligning the process where appropriate; and • the recommendations of this audit. 4.2 The health board should undertake a demand and capacity review in light of the updated processes, in order to ensure compliance with legislation and maintain patient safety.	4.1 CHC SOP to be updated to reflect recommendations. 4.2 Demand and Capacity review to be undertaken to ensure reviews are undertaken within required timeframes.	Mar-20	Apr-21	Overdue	2	Partially complete		Awaiting All Wales refresh and continuing to work with LA colleagues to reach a position of an agreed policy and SOP. Policy and SOP for endorsement as interim in May 2021, with early review date. Complex Care Value Based Healthcare Transformation Programme of work commencing October 2021. This will include review of the SOP, new national framework for CHC, joint working across adults, mental health and learning disability and a capacity review. This action will be transferred to the Programme's risk register to track to completion. 28/2/2022 As part of the restructure of the team in CSG betweeen November 2021and January 2022 the service was re mapped against activity and new pathways and a revised service model was implemented. 23.08.2022 - Scoping part of the work programme has been completed and the Complex Care Project Group is moving into a delivery programme. To support this the operational lead had been identified as the Assistant Director of Community Services and he will be supported professionally by the Lead Nurse for Transformation and Value in Complex Care. A governance structure is developing to support this work, including an Executive Director Group for Continuing Healthcare. The Complex Care Project Group and Continuing Health Care / Complex Care task and finish group meet fortnightly. 02.02.2023 - Workshop held on the 18th November and work through the Complex Care Delivery Group continues. The Transformation Lead for Complx Care contract finishes February 2023 and a final report being drafted. Once recevied a summary of the work undertaken including the Transformation Lead report will be presented to Executive Directors with recommendations for futrure working.	LA have requested to review the SOP and have contested some areas of the SOP 4.2 COVID19 has impacted on the way in which reviews are undertaken. Care home too busy to support completion, reviews completed virtually	We have started to utilise the practice within the new SOP 4.2 Support of bank staff to complete reviews	Apr-21		36	23	Mar-23	
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	Overdue	2	Partially complete		High level work has been initiated to outline the framework and principles. Feb 2022 update - some high level work commenced with this action in 2022 but due to a variety of factors the work has not been completed. The new Director of Corporate Governance / Board Secretary took up post in January 2023 and will ensure the development of the BAF is a priority for the 2023/24 year. Revised date requested to 31 January 2024. April 2023 - action is on track for Jan 2024, reports will be provided as the year progresses.	COVID-19	Agendas for all meetings continue to be scrutinised in order to ensure that the Board is receiving appropriate assurance.	Jan-24		12	0	Mar-23	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 bopard 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 Novemeber 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). 5. As part of a tour of PTHB sites alongside the Wellbeing roadshows, Welsh Language team staff have been visiting sites and advising on indiviudal locations by summer 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. 5 - June 2023		24	12	Mar-23	Sep-20
202108	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.	The Board has previously recognised the need for a Partnership Governance Framework. Development was delayed due to COVID-19. This will be taken forward in 2021/22 as part of the Annual Governance Programme.	Sep-21	Mar-22	Overdue		Partially complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position. Feb 2022 update - some high level work commenced with this action in 2022 but due to a variety of factors the work has not been completed. The new Director of Corporate Governance / Board Secretary took up post in January 2023 and will ensure the development of the partnership governacne guidance document is included for the 2023/24 year. Revised date requested to 31 March 2024. April 2023 - action is on track for March 2024, reports will be provided as the year progresses. April 2023 - The Live Well: Mental health partnership reports to each Regional Partnership Board meeting. An assuracne report will also now be included to the Boards Patient Experience, Quality and safety meeting on an annual basis. The report has been added to the Committee's work plan for 2023-24.	Lack of organisational capacity and within the corporate governance team	The Board's main partnership arrangements are reported to each Board meeting	By March 2024		18	12	Mar-23	
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. FEBRUARY '23 Capcity issues have delayed this being reviewed. An appointment to the 8b OH consulant nurse has been sucessful and they commence role Early March. It will be one of their first tasks to undertake. MARCH'23 OH Consultant Nurse now in post. Work has commenced on generic OH policy review, once amendments and additions have been finalised it will go out to service areas for consultation prior to exec sign off.	Capacity within the OH team has meant this has only partly been achieved		Generic OH policy review will be ready for consulation / comments end Aug with view to approval by execs in Sept	Exec meeting 13th July NS and BF policy approved	9		Mar-23	Aug-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R1	A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed.	Original replacement plan was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Secured DPIF Capital funding in 21/22 to help improve and enhance current infrastructure (but not to fully rectify and resolve), global market conditions and supplier delays resulted in alternative plans being deployed (linked to infrastructure development) to maximise use of the funding as available within time constraints. Further DPIF bids are being prepared for submission in 23/24 and beyond. There are also plans to move to the HCI platform to allow the legacy equipment to be decommissioned. This will also improve power and cooling.A realistic infrastructure replacement plan is being developed linked to the 4C report and this will be across a number of years and potential funding sources available.	Mar-23		Overdue		Partially complete		2008 servers identifed and some have already been upgraded/migrated and there is a plan to refresh all Windows 2008 servers 11/04/2023 - There are currently 6 Server 2008 servers in use. We are working with suppliers and internal teams to remove the remaining servers. This figure is down from 10 at the beginning of march. Work continues to remove Windows Server from the estate as quickly as possible.					0	0	Mar-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director - Digital Transformation and Informatics	R4	A process for ensuring patching of switches should be established.	Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid.	Mar-23		Overdue		Partially complete		Capital is sourced to replace part of the switch estate. Further funding is being sought for ongoing Switch replacement 11/04/2023 - A significant investment has been secured to replace switches in various location around the authority. A process for maintaining firmware willl be devised during rollout.					0	0	Mar-23	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		Overdue		Partially complete		a full audit has been completed of comms rooms, there will be a report available with requirements to be submitted to estates and facilities 11/04/2023 - No progress					0	0	Mar-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R6	A programme of re-cabling should be undertaken. Unsupported network devices should be removed from the network A review and associated upgrade of Wi-Fi provision should be undertaken	Dedicated Programme Manager post established to lead on this area and to identify options and develop a plan over a reasonable timescale to improve (link to 4C report). Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured.	Mar-23		Overdue		No progress		Project manager is in post and working with suppliers on the specificaiton and quality control for cabling requirements 11/04/2023 - Work is ongoing to address the health boards cabling infrastructure, we are currently working with estated to ensure that all contracted work complies with all applicable standards before implementation.					0	0	Mar-23	Sep-22
222301	IT Infrastructure and Asset Management	Limited	Director of Finance, Information and IT	Assistant Director Digital Transformation	R7	The network should be split into Vlans. The firewalls should be deployed.	Network re-design plane is being developed and will include implementing the segmentation identified. The Digital Transformation team are overseeing the wider infrastructure improvement plan (which is reliant on strengthened capability and investment). This is aligned to the All-Wales Infrastructure Programme. Firewall implementation has started and is in progress lead by the Head of Cyber Security.	Mar-23		Overdue		Partially complete		The firewalls have been deployed and there is a design plan to segment the network and implement V-Lans 11/04/2023 - New switching and wifi infrastructure procured at the end of 2022/23 FY will allow the design and implementation of segmented vlans. This is a significant activity and may take most of 2023/2024 to implement.					0	0	Mar-23	Sep-22
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R3	Management to ensure that the Welsh Language Policy along with any staff guidance is up to date, accurate and published as soon as possible on SharePoint for point of reference for all staff. The existing Health Board response to this standard has taken the form of a mangers' guidance document, however the Audit has called for a formal policy; the Welsh Language	The Welsh Language Team will develop a formal Welsh language policy summarising the Health Board's position.	Jan-23		Overdue		Partially complete		Policy has been drafted and is awaiting review by Execs. Expected completion end of May 2023.					2	2	Mar-23	Jan-23
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		Jun-23		24	12	Mar-23	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	Overdue	3	Partially complete		Policy now updated and approved with Asbestos Management Plan to be agreed in Asbestos Management Group. Last element related to 'labelling' now agreed and finalisation of document and approval at next meeting only now outstanding	Procedural elements have needed to be agreed collectively by Asbestos Safety Group which meets bi-monthly	Operational management remains robust. Rationalisation and clarity of documentation will reduce paperwork and introduce site specific management plans.	Aug-23		26	4	Mar-23	Sep-20
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	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.			01/04/2023	Yes via meeting minutes & action logs	12		Mar-23	

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 Novermber. Will implement guidelines & establish pathways as required. Will ensure KPI's are in line with national requirements when released.			Jun-23		10		Mar-23	
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		Partially complete		The Health Board has daily oversight via CTC's on the number of patients requiring repatriation back to Powys. Whilst CTC's are not employed 7 days per week the position on a Monday morning is quickly understood. The Health Board will pick up demand and capcity planning as part of 23/24 overall IMTP planning			Jun-23		8		Mar-23	
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		Overdue		Partially complete		A Teams Channel has been created for for both Medical Devices Team and Procurement to access and update the preferrend equipment list. This work includes any All Wales contracts being added by Procurement. Medical Devices Team have reviewed items and categories listed. The list will be presented to the MD&POCT Group in March 2023 for comments to ensure it continues to be efficient and user friendly. 2 & 3. Constant monitoring of EDOF requests by Medical Devices team to ensure Procurement are engaged where applicable and that forms are completed fully. This whole item will be closed by May 2023.	Resource within Medical Devices Team.	Regular meetings and monitoring with Procurement. EDOF process monitors equipment being requested.	This will remain an ongoing action as the preferred equipment list requires constant monitoring and updating in conjunction with Procurement.		4		Mar-23	
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 received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document to be presented to MD&POCT Group in March 2023 for approval across all services. Full implementation can then take place.	Limited resources to undertake audits to gain assurance that all services are compliant.	Regular monitoring and reporting into Medical Devices Group.	Examples of evidence received from Governance Leads. Standard template is being developed by Medical Devices Team through the additional resources secured on a temporary basis. Indemnity document has been drafted and to be to be shared with MD&POCT Group for approval across all services. Full implementation can then take place. Audit, undertaken locally, will be required to monitor compliance. These will need to be service led as there is no capacity within the Medical Devices Team to undertake these. Assurance from services will be via Highlight reports into MD&POCT Group. This should be completed by the end of May 2023		16	13	Mar-23	
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. Shared with MD&POCT Group members in October 2022 and agreed at Novermber MD&POCT Group. Comments received and to be added to matrix. SBAR is being drafted to identify the issues and risks around training.	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		12		Mar-23	
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	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 provided an opportunity to strengthen processes in this area and identify cost savings. Additional resource has also enabled contract monitoring meetings to be reinstated. However, this won't be feasible in the long term without permanent support in this area.	Resource prevents progress in this area.	Contract monitoring meetings held for some providers.	Without any additional support it is difficult to understand how the health board will be in a position to strengthen contract monitoring processes and therefore obtain assurance on compliance.		11		Mar-23	
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		Overdue		Partially complete		WPOCT implementation will strengthen governance in terms of quality control checks. WPOCT project has commenced but not completed. Project Manager role has progressed but delay in IG approval has impacted on being able to deliver within a specified timescale.	Resource prevents progress in this area.	Awareness raised through Governance Leads of the importance of quality control checks and robust recording, abeit currently in manual format.	Funding has ceased for the Project Manager role, and following IG delays this has significantly impacted implementation. Gradual progress is being made in WPOCT implementation for INR devices across all sites; revision of timescales in light of project manager funding ceasing is underway. This role will need to be absorbed within the MD&POCT Team. This is proving a challenge from a capacity, skills and knowledge aspect. Further discussions held with neighbouring health board and agreement from Executive Director to explore options to strengthen POCT governance within the health board. Briefing paper under development.		3		Mar-23	
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 Safeguardng cases. * Abbi Maddox Interim Head of Midwifery & Sexual Health to meet with Rachel Mills Safeguarding Midwife on a monthly basis to be sighted on training and required updates. * Learning to be embedded through Joint Shire Meetings with Midwifery & Health Visiting services using Safeguarding scenerios on a quarterly basis. Feb 2023 - update - change in senior management team in January 2023 - management meeting weekly agenda amended to ensure sfaeguarding supervision compliance and any specific updates are standard agenda 2nd week of the month from now on. Safeguarding midwife has database of attendnace at quarterly sessions which will be shared with managment team at those meetings also supporting mechanism for escalation B7 team leads will be expected to feed back monthly on compliance on many elements including safeguarding for their teams safeguarding midwife also booked for March 2023 all Powys team meeting to provide further update for staff around safeguarding	Issues regarding release of staff due to staff shortages/clinical demand Limited number of sessions which are not always available when convenient for all staff to attend	request that team leads allocate protected time for staff to attend which is rostered, preventing clinical work to be allocated to individual. Lead midwife for safeguarding, to commence in post 29/08, who will support midwives to attend Midwives aware can access safeguarding team re any concerns about specific cases	Expected improvement in compliance by end of Q3; Monitored via Safeguarding Strategic Group and added to W&C dashboards. Feb 2023 - expcted improvement by April 2023 in view of changes in senior structure in Jan 2023		15		Mar-23	
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. April 23 Update - currently being recruited to	Unable to fully mitigate the risk	During current financial year	01/06/2023		12		Mar-23	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. Feb 23 update - this is being included as part of our IMTP planning for 23/24. PTHB will apply for additional funding via the Elective Recovery Fund to afford the costs incurred. April 23 update - the Health Board is in the process of applying for it's population share of the £50m to enable this to occur. All schemes likely to start due qtr 1 23/24	Currently waiting for NHS Wales DU to assemble patient lists to enable selection from other HB waiting lists (for potential repatriation)		01/06/2023		12		Mar-23	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 withiin the host provider. Feb 23 update - CQPRM meetings include enhanced oversight. the Commissioning Team's programme of work for 23/24 includes a formal review of this area and the application of a consistent approach to all inreach SLA's			01/07/2023		12		Mar-23	Jan-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		Overdue		Partially complete		Additional reporting in place and PTHB continues to review compliance against JAG standard. 1 unit now JAG accredited with the 2nd unit seeking accreditation during 22/23			01/04/2023		#VALUE!	#VALUE!	Mar-23	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			Jun-23		14		Mar-23	Jan-22
212207	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. Update - this service is currenty being reviewed as part of the wider ASM work. The eventual model will be incorporated into our OBC	Additional financial resources are required in order to operate the service on 7 day basis.	Should patients deteriorate over weekend, inpatient and MHA processes are available.	7 day working for the DHTT will be considered as part of the Mental Health transformation work. Completion date will exceed the agreed deadline for this action.	Jun-23	3		Mar-23	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.	Jun-23	3		Mar-23	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	Overdue		Partially complete		Some further changes to the document are required. The document will then go through the process that will close with consideration by the Board. We have reviewed the document following completion of our contract award, but also reflected on progress in other HBs -and our document will be finalised and through necessary governance by December 2022	Obtaining an agenda slot at the relevant workforce Policy Review Group followed by an Executive Team meeting prior to consideration of the revised document by the Board. Extention to deadline requested due to committee timetables.	An extant PTHB waste policy exists that can be used as a reference. WHTM 07-01 is followed as best practice guidance.	Nov-22		10	3	Mar-23	Apr-22
222303	Security Services	Reasonable	Director of Environment	Assistant Director of Support Services	R2	Management should remind all Departmental Managers of the requirement for having Security Protective Measures plans in place for their areas of responsibility. Management should consider developing a template for the Security Protective Measures Plans for Security Leads to complete. This will allow for consistency in the information being recorded.	An internal communication will be made to all Departmental Managers advising them of the latest version of the Security Protective Managers Policy and its location on Sharepoint. b. This action will be discussed further during the next Security Oversight Group Meeting in December with the meeting invitation distribution List extended and updated to include a wider representation from all Departments across PTHB. A 30 minute slot has been reserved on the agenda for the next Site Coordinators Meeting and Health and Safety Groups in January 2023, to discuss the Security Protective Measures Policy and to deliver the toolbox talk on the preparation of Departmental Security Plans.To date, Departments have been encouraged to use the standard risk assessment template to develop Security plans as it provides a template to assess existing risks with a revised risk following risk mitigation and consideration. A dedicated template document will be developed to record Security plans and this will be presented to the December 2022 Security Oversight Group Meeting for consideration	Feb-23		Overdue		Partially complete		Due to change over of Assistant Director role further work is planned around the template for Security Plans to be disucssed at HSG and SOG. Security Oversight Group attendance extended to cover more service representatives. Communitcation around Site Security, new web pages, Policy and future survey will be shared via Powys Announcements in April 2023 The PTHB Risk Assessment form as a template document for Departmental Security plans. JM will amend a current document with some topic headers to aid evaluation and add to the Security Site on Sharepoint					1	1	Mar-23	Nov-22
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	Director of Environment	Project Director	R2	a) All project variations should be approved in line with the Standing Orders. b)W here the THB wishes to vary the delegated financial limits contained within the Standing Orders, a project-specific scheme of delegation should be defined and formally approved at an appropriate level for application at future projects. c) Noting timeliness of contract execution is a recurring audit recommendation at the THB, management should develop an acceptable procedure to facilitate the signing of agreements / contract documentation in a complete and timely manner. 2.2) Project Board minutes should clearly record when a	a) Agreed. b) Project-specific scheme of delegation will be considered / implemented, dependent on value of project, to administer variations whilst still maintaining the governance criteria for overall cost control for future major projects. c) Strengthening of process to ensure timeliness of signing of agreements / contract documentation will include investigation of electronic signatures and possible delegation of authority for signing of construction related contracts. 2.2) Project Board minutes will clearly record decisions made and approvals granted.	Jan-23		Overdue		Partially complete		a) Complete b) This will be implimented on future major schemes discussions are taking place regarding governance arrangements c) To be implimented on future schemes electronic signatures being implimented - to be discussed with Board Secretary d) Complete					2	2	Mar-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R6	The service mapping should be updated to ensure the programme has continuous relevance in providing a clearer picture to services to users, encouraging solidarity of stakeholders especially locals of North Powys accepting change and importantly supporting the required service transformation plan.	A full review of the service mapping has been carried out and updated and aligned to the 5 transformation areas of work.	Jan-23		Overdue		Partially complete		2 workshops have been undertaken in order to review service mapping. The remaining workshops were stood down due to winter pressures, industrial actions preparation and wider assimilation with the Accelerated Sustainability Model work. Further service mapping has occurred to update from 2014 following recommendations as part of the Internal Audit				Jun-23	2	2	Mar-23	Jan-23
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R7	Management should ensure the membership agreement is sorted promptly for the smooth running of the governance framework and the programme as a whole. Management should also encourage key staff to attend their respective programme meetings drawing their attention to the quorate requirement stated in the ToR in the Governance framework.	Majority of work areas have now identified leads from respective organisations who attend Programme Delivery Team on a monthly basis with the exception of the social model for health transformation area.	Jan-23		Overdue		Partially complete		Workstream leads have been identified however some delay in progressing all workstreams for the reasons outlined above				Jun-23	2	2	Mar-23	Jan-23
222307	Looked After Children Health Assessments	Substantial	Director of Nursing and Midwifery	Director of Nursing and Midwifery	R1	Management should ensure that Data entry checks are undertaken to ensure that information held within the LAC Spreadsheet is correct and up to date.	Weekly spot checks by Business support manager of the LAC spread sheet in place. Immediate action in progress and already commenced. The LAC Team had identified the LAC Spreadsheet needed to be updated due to the amount of information it was holding and the time involved in updating the data. The process of redesigning a new system that will improve data collection, imit human error and enable a more efficient use of time has already commenced and will be ready for testing January 2023.	Jan-23		Overdue		Partially complete		spot check of current data speadsheet being undertaken weekly. New data collection/storing system built and ready for testing.		weekly spot checks	new data system will be in place March 2023		1	1	Mar-23	Jan-23

ITEM 3.9ii APPENDIX E - AUDIT RECOMMENDATIONS COMPLETED SINCE PREVIOUS REPORT

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Due	COVID-19 Priority Level	Status	If closed and not complete, please 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	How is the risk being managed?	When will implementation be achieved?					
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	Complete	3	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. FEBRUARY '23 A review of the OD framework ,its objectives and where they sit and actions undertaken todaye is currently being drafted. The reviw will be presented at Excs (end Feb) and the to Workforce and Culture committee in March'23. UPDATE MARCH 2023 - OD Framework end of year report presented at Workforce Steering Group 2nd March 23. The report demonstrated that progress had been made against each of the key priority areas. The report referenced that future actions to meet each of the key priorities are held within the IMTP across a range of directorates and are also in strategic programmes of work. Going forward it was agreed to : • Monitor OD framework progress through the IMTP reporting • Develop a public facing document that describes the culture of working in PTHB which will be a helpful resource for recruitment		This will be reviewed as part of the reintroduction of BAU	end of Qtr 2		36	30	Mar-23	
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	Complete		Complete		Overview of partnership governance arrangements presented to board at Strategic Planning Session as an interim position. Feb 2023 update - the partnerhsip governacne arrangements guiance will follow later in 2023/24 but clarity on the Live Well: Mental health partnerhsip will be confirmed for end March 2023.	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		18	12	Mar-23	
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		Complete		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.		Worktream 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. There was clinical involvement in the working group for Phase 2. The Progamme is no longer in place with further actions being taken forward via the Commissioning Department.		16		Mar-23	
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	Complete		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 IMSOP review. This action should be closed. An approach was developed and supported through the Executive Committee Transformation and Programme Group and embedded in the Renewal Portfolio. The South Powys Programme is no longer in place.		18	12	Mar-23	
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		Complete		Complete		As of 1st December 2022 transferred from implementation phase to "business as usual." To enable progression to this stage, additional hours were supported for a period of 7 weeks.	Resource within Medical Devices Team.	Implementation phase has now been completed, routine validation of the system will occur as part of "business as usual".			15		Mar-23	
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		Complete		Complete		CSM has requested urgent engagement with Estates to address this. Update from Ward Manager - new storage unit being built to store equipment. COMPLETE. Work continues with services to encourage completion of the Medical Devices Audit. Barriers have been identifed as to why audit is not being completed. This was reported into IPC Group, advised to liaise with Heads of Nursing to embed across all services.	Capacity within clinical teams to complete medical devices audit.	Medical Devices Audit to be escalated to Heads of Nursing.	Update from Ward Manager - new storage unit has been completed to store equipment. Communications were sent out as required by audit.	Confirmation received from Ward Manager	12		Mar-23	
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		Complete		Complete		This has been considered ! 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 22. ME process fully rolling out. Feedback mechanisms maturing and learning will be strengthened in revised TOR for learning group. March 23- ME service roll out continues. Process is in place for ME feedback via PTR team. Cases reviewed with AMD support. Reecorded on Datix. Feedback given to service groups ang themes fed through learing group process.			Feb-23		#VALUE!	#VALUE!	Mar-23	Apr-22

212214	Occupational Health Service	Limited	Director of Workforce and Organisational Development	Assistant Director of OD	R3	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		Complete		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. FBRUARY '23 - KPIs in developemnt will be a key task once 8b OH resource is in place. KPIs will also form part of the new OH mgt system (CIVICA) due to go live in 2023. Information for ' When should i refer to occupational helath' included on share point pages. MARCH'23 KPIs for timelines within OH services are in place and set to run from 1st April . The cohort OH management system will provided compliance data with the set timelines and will be used to provide a high level OH management information dashboard. This will be possible from 1st May following one months KPI tracking	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		6		Mar-23	Aug-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		Complete		Complete		Appropriate KPIs will be developed following 3 month period of monitoring trends Sept-Nov. FEBRUARY '23 KPIs will form part of the new OH mgt system (CIVICA) due to go live in 2023. There will be a a set on all Wales KPIs and dashboards to utilising once all HBs have moved to the new system in 2023. We are currently capturing timeline data that we will use in the interim to assess effectiveness of PECS. MARCH'23 KPIs for timelines for Preemployment checks within OH services are in place and set to run from 1st April . The cohort OH management system will provided compliance data with the set timelines and will be used to provide a high level OH management information dashboard. This will be possible from 1st May following one months KPI tracking.	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		5		Mar-23	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		Complete		Complete		Detailed dashboard yet to be developed- Reliant of above KPI data sets to be fully in place. FEBRUARY '23 KPIs will form part of the new OH mgt system (CIVICA) due to go live in 2023. There will be a a set on all Wales KPIs and dashboards to utilising once all HBs have moved to the new system in 2023. We are currently capturing timeline data that we will use in the interim to assess effectiveness of PECS. MARCH'23 KPI for Pre employment checks (PECS) receipt of PEC to clearance of 10 working days KPI for Management and Self referrals receipt of referral to first offer of an appointment - 20 working days	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		5		Mar-23	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		Complete		Complete		Feb 2023 - training material is in development. Roll out has not yet commenced due to staffing changes, wil continue from 1 May 2023. April 2023 - A plan is now in place to roll out training in Q3 and Q4 of 2023/24 - this will include risk appetitie review and training for the Board early Q3, the Risk and Assurance Group later in Q3 and then directorates in Q4 rolling into early 2024/25. The training will be supported by a refreshed risk toolkit and training package. In the meantime risk management training continues to be available to all staff via ESR. Action proposed to be closed on this basis, theprogress against implementation will be tested in the risk management audit for 2023/24.					5	5	Mar-23	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		Complete		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. PID not considered by Executive Committee in November 2022 due to the Accelerated Sustainable Model programme work. This has allowed for a further addition to the PID about the Wellbeing of Future Generations (Wales) Act 2015 as required by the Audit Wales findings from its audit of the Renewal Portfolio. This version of the PID will be considered for approval by Transformation & Value Group Executive Committee on 09/03/23. PID approved by Executive Committee on 09/03/23 - action complete.	The updated PID, Breathe Well Programme Team and Breathe Well Programme Board minutes and the Transformation & Value Group Exec Committee minutes can provide evidence.	5		Mar-23	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		Complete		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. PID not considered by Executive Committee in November 2022 due to the Accelerated Sustainable Model programme work. This has allowed for a further addition to the PID about the Wellbeing of Future Generations (Wales) Act 2015 as required by the Audit Wales findings from its audit of the Renewal Portfolio. This version of the PID will be considered for approval by Transformation & Value Group Executive Committee on 09/03/23. PID approved by Executive Committee on 09/03/23 - action complete.	The updated PID, Breathe Well Programme Team and Breathe Well Programme Board minutes and the Transformation & Value Group Exec Committee minutes can provide evidence.	5		Mar-23	Aug-22
222303	Security Services	Reasonable	Director of Environment	Assistant Director of Support Services	R4	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.	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	Feb-23		Complete		Complete		Reminder sent to all Assistant Directors Feb 2023 to encourage representation and outline future plans, policy deployment and associated baseline security knowelge survey					1	1	Mar-23	Nov-22
222303	Security Services	Reasonable	Director of Environment	Support Services Manager	R6	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.	Additional administration support is now provided to ensure that actionable items are completed and signed-off appropriately. 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.	Dec-22		Complete		Complete		SOG action log is reviewed and progress monitored by the group, items identifed remain under close review.					3	3	Mar-23	Nov-22
222309	Womens and Children's Services	Substantial	Director of Primary, Community Care and Mental Health	Assistant Director of Womens and Childrens Services	R1	Team Leaders should ensure that Return to Work Interview Forms are completed and signed off by both parties as soon as is practicable upon a staff member's return to duty.	We acknowledge that on this occasion the forms weren't completed as per policy and will endeavour to improve on this moving forward, however the sample period was during a time of operational challenge.	Mar-23		Complete		Complete		Audit recommendation shared with team leads and the W&C Senior Clinical Leadership forum in January 2023. The audit report also formed part of the Childrens Quality, Assurance and Learning Forum agenda on 15/03/2023 where all the Children's team leads are in attendance.					0	0	Mar-23	Jan-23
222310	Machynlleth Hospital Reconfiguration Project	Reasonable	Director of Environment	Senior Internal Project Manager	R3	An operational (occupation) commissioning plan should be developed. The Project Board should receive routine updates on progress against the operational commissioning plan.	Formal operational commissioning masterplan will be produced to identify aspects of activity for the health board to successfully occupy the completed facility, to include items highlighted within the Capital Investments Manual. Project Board agenda will reflect standing item to receive updates on progress against the operational commissioning masterplan.	Dec-22		Complete		Complete		Plan developed and shared with stakeholders			01/03/2023		3	3	Mar-23	Jan-23
222313	Workforce Futures	Reasonable	Director of Workforce and OD	Strategic Workforce Lead for Health, Care & Partnership	R1	Management should ensure that the Annual evaluation on the 2022 outcomes is reported in January 2023 as planned, to confirm if all the outcomes had been achieved or if there was any further action required on them.Consideration should be taken as to whether more regular reporting than annually should be undertaken on the themes and outcomes to ensure that if there is any slippage this can be identified earlier.	The annual evaluation on 2022 outcomes is planned to be added to the agenda for the next Programme Board which is scheduled for the 6th February '23'. NB Programme Board for January '23' was rescheduled to 6 th February due to winter pressures.	Feb-23		Complete		Complete		FEBRUARY '23 A high level dash board of the draft WFF annual review is due to be presented at WFF programme board 6/2/23 and permission sought for the 2 x SROS to approve the full review outside of the meeting to enable it to be presented at the next RPB meeting and RIFF funding submission. - The full review will then be tabled at the next programme board. MARCH'23 WFF annual review and report presented and approved at WFF programme board 13/03/23					1	1	Mar-23	Jan-23
222313	Workforce Futures	Reasonable	Director of Workforce and OD	Workforce Futures Business Manager	R2	There should be narrative on all actions within the minutes of both the Board and Group to confirm whether they have been completed, reasons for revised dates and information to where the new actions have originated from.	Narrative on all actions within the minutes of both the WFF programme Board and Oversight groups will be included at all meetings minutes from this point onwards (January '23). This will include reasons for revised dates and information to where any new actions have originated from.	Feb-23		Complete		Complete		FEBRUARY '23 WFF programme board meeting to be held 6/2/23 where this will be addressed (jan meeting rescheduled) MARCH'23 Action log narrative and dates included at WFF programme board 13/03/23					1	1	Mar-23	Jan-23

222313	Workforce Futures	Reasonable	Director of Workforce and OD	Strategic Workforce Lead for Health, Care & Partnership and Workforce Futures Business Manager	R3	Consideration should be taken to having other named representatives to attend the Workforce Futures Programme Board on behalf of the actual representatives when they are unable to attend the meetings, to ensure that the Board meets bi-monthly going forward. The Workforce Futures Programme Board should report into the Powys Regional Partnership Board on a regular basis in line with the terms of reference. In cases where they have nothing to report they should confirm this.	This will be an agenda item at the next Board and oversight groups to ensure named representatives attend and/or provide a deputy with approved decision making authorisation. The Workforce Futures Programme Board will submit an update progress report into the Powys Regional Partnership Board twice per year.	Mar-23		Complete		Complete		MARCH'23 Named representatives and Deputies requested at WFF programme board 13/03/23. Updates on WFF programme of work scheduled to be onward reported at RPB meetings – a minimum of twice per year					0	0	Mar-23	Jan-23
222313	Workforce Futures	Reasonable	Director of Workforce and OD	Strategic Workforce Lead for Health, Care & Partnership and Workforce Futures Business Manager	R4	The Workforce Oversight Group should ensure that they carry out the work that is required to be undertaken as directed by the Strategic Workforce Futures Programme Board	Actions allocated to the oversight group from WFF Board should be tracked and reported as part of the WFF highlight report at each meeting.	Jul-23		Complete		Complete		Actions from oversight group or task and finish groups are included in highlight reports					#NUM!	#NUM!	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R1	a) The Welsh Language Department should undertake a review of all existing action plans as soon as possible to determine if the standards originally assigned to all the services are still appropriate and applicable. This will also ensure that all the standards from the compliance notice have been assigned to an appropriate service area. This will also provide an opportunity to ensure that an up-to-date position is recorded for each of the standards within each action plan, along with identifying the appropriate service leads /responsible officers for each area. The Welsh Language team should encourage the service leads to devolve and further cascade the action plans to aid the implementation of the standards within their area. b) The responsible officer / service lead should be reminded about the requirement to complete all the columns identified within the action plan which includes evidence, possible action required to meet the standard, and ensure there is an up to date "target date".The Welsh Language team should also reiterate to the Service Lead for the action plan the need to provide regular updates on the status of individual action plans to the Welsh Language Team, as this could help identify areas of non-compliance. Areas of non-compliance and issues will be escalated to the Executive Director of DoTHs as Exec lead for Welsh Language and this will be raised with individual Directors and/or Exec Committee.	a) Welsh language team to review existing action plans to ensure they reflect the standards applicable to each team / department. Identify any outstanding issues.Welsh Language team to contact each service area to ask for a contact who would have responsibility for the Welsh Language.Contact list to be verified with Hayley Thomas.Meetings set up with each new contact to look at establishing new work plans: Contact made with each area. Meetings to be arranged.New action plans in place and quarterly catch-up meetings established between Welsh Language team and service areas. b) New action plans in place and quarterly catch up meetings established between Welsh Language team and service areas.Welsh language team to develop & share guidance on how to complete the action plan. Service contacts to update work plans prior to quarterly meetings so they can be discussed.	Dec-22		Complete		Complete		Contact list drawn up and approved by HT. A new revised template action plan has been developed and distributed on 1/2/23. In the same message departments were invited to arrange 1:1s with the Welsh team to discuss completion of the action plans, in preparation for a new date for the next Quarterly catchup meeting (15th March). Meetings have taken place with a number of departments. Update: Action plans have been reviewed and changes made; all departments have been reminded of the need to review and update action plans and specifically th need to complete all columns. This will be reviewed on an ongoing basis via the Welsh Language Service Leads group. Therefore completed.					3	3	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R2	Management should ensure that they meet with all service action leads on a regular basis to review and note progress on the compliance of standards noted in the action plans. This will then help to inform the overall compliance position noted in the Standards Monitoring Document maintained by the Welsh Language Department.	Senior Managers to ensure Welsh is a recurring agenda item in their regular service meetings. Service managers to ensure good attendance at quarterly Welsh Language service leads meetings quarterly. Escalate attendance issues or other areas of concern to senior managers, ADs & DDs. Welsh Language team to update the Standards Monitoring Document quarterly following meetings with service areas.	Mar-23		Complete		Complete		First Quarterly meeting scheduled for 15th March; this has now taken place and these have been included as action points for all departments.					0	0	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R4	Management should consider implementing a new process whereby appropriate discussions and scrutinisation of the action plans can be undertaken across the Health Board and includes providing regular updates on the compliance with the standards to an appropriate Executive forum. Consideration should be given to re-establishing the Welsh Language Service leads group which has defined reporting lines, and an appropriate membership and a Terms of Reference in place. Establishing this process could help to identify areas of concern / weakness which may need to be escalated whilst also identifying good practice which could be used to cascade to other Service Leads.	Update Welsh Language Service Leads Group Terms of Reference drafted ready for exec. Consideration. Terms of reference to include clear lines of accountability. ToR to be approved by Execs. Welsh Language service leads group to feed into regular appropriate Executive Forum in the Health board to ensure issues and good practice are fed back to Execs – Workforce and Cultures committee. During 2023, the Welsh team or designated deputies will carry out in-person on site audits of all main PTHB sites to establish whether compliance on-sites has improved.	Jan-23		Complete		Complete		New Service Leads group met 15th March and approved TOR.					2	2	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R5	Looking forward to the production of the Welsh Language Report for 22/23 management should ensure that appropriate engagement takes place with the Leads for each Service action plans to ensure that the position is appropriately reflected within the report.	Updates for the Welsh Language annual report and items to be included discussed regularly with the service leads Welsh Language contacts in quarterly meetings. Information collated for the annual report by the Welsh Language team and checked with services prior to presenting to Execs.	Mar-23		Complete		Complete		This will be a point for the Agenda on 15th March.					0	0	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R6	A review of all temporary signage should be carried out across the Health Board. The Welsh Language team should liaise with the Estates Department and all Service Leads / Responsible officers to determine the most common temporary signage that are used in their Service Groups and across the Health Board. Signposts to these bilingual signs should be available on both the Estates and Welsh Language Share point pages to direct staff to the most common signs, but also highlight who they can contact if they need help to translate any other temporary signs.	Signage guidance and Library of temporary signage up on Welsh Language Sharepoint pages. Welsh Language team to join the Estates away day in October 2022 to discuss sharing Resources and linking on sharepoint. Test & Learn of audit of signage to be undertaken by the Therapies Department. Each service area to do an audit of their own areas/ wards to check temporary signage and update (audit tool to be developed following pilot with Therapies). Good practice shared by the Welsh language team across other departments. Welsh Language team to check areas and wards on their roadshows during.	Mar-23		Complete		Complete		Welsh langauge team joined the Estates away day in October 2022. Common signage list has been drawn up and is undergoing translation; initial informal audits are taking place as part of the Roadshows.Good practice has been shared in the Service Leads group and they have been asked to audit their own areas. Update: All sites have now been reviewed and non-compliance escalated as appropriate. In the 15th March meeting all departments were reminded to ensure compliance across all areas where they have responsiblity for signage. A common signage area is on the intranet and linked from both Welsh and estates Sharepoint sites. No further action required.					0	0	Mar-23	Jan-23
222314	Welsh Language Standards	Limited	Director of Therapies and Health Science	Welsh Language Team	R8	In light of the issues regarding Welsh Language Standards compliance identified in this report management should review the risk assessment for CRR 012 – Compliance with Welsh Language Standards, to establish if the position that has been/ is being reported is accurate or whether it may be overstating the current controls in place. Management should also consider where issues regarding compliance with the standards are identified in individual service action plans management should undertake risk assessments to determine if the matter should be considered a risk and added to the departmental risk register.	Welsh Language discussed internally with DoTHS. Reviewed Quarterly. Welsh Language Team to meet with Senior Managers to discuss including Welsh Language Standards on departmental risk registers.	Jul-23		Complete		Complete		Individual departments have been instructed to include this on their own risk registers as appropriate.					#NUM!	#NUM!	Mar-23	Jan-23
222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Head of Financial Services	R3	Whilst Gift Aid claims can be submitted to HMRC on a quarterly basis, management should consider submitting the Health Board's claim at least annually.	Agreed - Gift aid claims will be undertaken on at least an annual basis	Jun-23		Complete		Complete		This has been completed and is now in operation. For example, claim submitted in Feb 23 includes up to Sep 22 and the next claim will be made Q1 23/24 for final 6 months of 22/23 financial year.					#NUM!	#NUM!	Mar-23	Jan-23
222312	Charitable Funds	Reasonable	Director of Finance, Information and IT	Head of Financial Services	R5	Management may wish to consider the development of a sign off checklist to concisely summarise when supporting documentation was completed and where it is located.	Agreed a template will be developed and retained for approvals and subsequent actions and dates taken on these approvals	Mar-23		Complete		Complete		A template has been developed and is in use.					0	0	Mar-23	Jan-23

ITEM 3.9iii APPENDIX F - AUDIT RECOMMENDATIONS NOT YET DUE FOR IMPLEMENTATION

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	How is the risk identified being	When will implementation be					
222303	Security Services	Reasonable	Director of Environment	Assistant Director of Support Services	R3	Management should consider reviewing all Security Plans at least annually at an appropriate forum such as the Security Oversight Group.	Security plans will be reviewed annually through the governance structure which will consist of the Security Oversight Group, The Health and Safety Group and the Site Coordination Forum. Security plans will be completed and filed centrally using Sharepoint, to ensure that Departments are referencing up to date policy documentation and forms.	Dec-23		Not yet due		Partially complete		Business cycle from April 2023 will include cycle of site based audits for review by the group to establish annual reviews. AN example of a Security Assessment is to be shared with Services in April to prompt awarness and work to improve the Web Site Resources will be made available.					#NUM!	#NUM!	Mar-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Environment	Director of Environment	R1	PTHB should look to formalise Decarbonisation oversight arrangements within the Terms of Reference of existing committee/ meetings.	The Environment Sustainability Group (chaired by the Director of Environment) provides escalate/exception reports to the Innovative Environments Group (chaired by CEO) and then on to the Delivery and Performance Committee.When terms of Reference are reviewed at normal intervals the need to be more specific about reporting detail will be considered.	Oct-23		Not yet due		Partially complete		ToR for Environment and Sustainability Group will be updated in Q2 for approval by Q4. Agreed process for model of alternate meetings with core and full ESG attendance					#NUM!	#NUM!	Mar-23	Nov-22
222306	Decarbonisation	Not Rated	Director of Environment	Director of Environment	R2	The governance arrangements surrounding the respective work groups assigned specific initiatives and corresponding actions should be aligned to those set out in the paper presented at the Innovative Environment Group, with enhanced accountability for delivering plans formally set out.	This action will be considered when a new version of the Decarbonisation Plan is developed. The current plan does have actions through to 2030 however there is a current expectation that a revised plan will be submitted as part of the IMTP planning cycle for 2024/25 onward. It is however necessary to not focus all actions on decarbonisation and climate impact on a single plan if we are to embed the issue in all departmental plans.	Dec-23		Not yet due		No progress		Outcome will be dependent upon changes made during 2023					#NUM!	#NUM!	Mar-23	Nov-22
222311	North Powys Wellbeing Programme	Reasonable	Director of Primary, Community Care and Mental Health	Senior Responsible Officer	R5	An updated benefit framework should be developed to ensure clarity and relevance to the phase of the Programme but most importantly to meet with the overall desired outcome of the North Powys Wellbeing Programme	A review of the Benefit and outcomes framework to be undertaken, included on the OBC Programme Plan and due to sign off Q3 2023.	Dec-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Jan-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director and Head of Therapies	R1	Review and finalise current policies and procedures and ensure they are referenced within the Professional and Clinical Governance Framework.	The organisation Professional Registration policy review is to be finalised The organisation Clinical Supervision procedure review is to be finalised Both documents to be referenced in the overarching framework document referenced in Matter Arising 2.	Jul-23		Not yet due		Partially complete							#NUM!	#NUM!	Mar-23	Mar-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	R2	The Health Board should implement a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions regulated by the HCPC and other professional bodies.The structure should also include a forum that oversees, advises and coordinates appropriate application of professional accountability and use of professional title for Health Board Therapy and Health Science professionals which are currently in place within the four departments sampled.	Implementation of a formal, overarching, and clearly defined professional and clinical governance framework covering all Therapy and Health Science professions.	Oct-23		Not yet due		Partially complete							#NUM!	#NUM!	Mar-23	Mar-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	R3	Liaison should be undertaken with the Workforce and OD Directorate to explore the possibility of developing a process for recording the HCPC registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service. This would be the most efficient and effective way of ensuring all relevant staff are identified at the point of commencing with the Health Board.	Strengthening of the Workforce and OD Directorate process for recording the professional registration number at the point of enrolment on ESR and communicating this to the Professional Heads of Service.	Oct-23		Not yet due		Partially complete		Meeting held with WOD 28.03.2023 - recruitment process and ESR capability to be looked into further to support achievement of this recommendation.					#NUM!	#NUM!	Mar-23	Mar-23
222315	Therapies and Health Sciences Professional Governance Structure	Reasonable	Director of Therapies and Health Science	Professional Heads of Service	R4	Management should ensure that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Professional Heads of Service to provide assurance that all relevant staff who are not operationally managed by a Professional Head of Service receive appropriate training and CPD support as part of their PADR.	Oct-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23
222316	Incident Management	Reasonable	Director of Nursing and Midwifery	Assistant Director of Quality and Safety	R1	Management should ensure that: All incidents are managed in accordance with the required timescales; Staff are clear on how to assess the level of harm caused as a result of the incident Lessons learnt only state the learning from the incident reported, communicating it to the relevant teams and groups; Evidence of meetings held should be adequately stored for ease of future use or reference; and • Staff are Root Cause Analysis trained prior to undertaking incident investigations (where required). The formal documentation of the requirement and processes within a Health Board specific procedure (as per recommendation 2.1 below) will provide a platform where the due process can be referred to minimising the findings noted from the review.	Processes to ensure monitoring of timely incident management are established to escalate delays when incidents are not managed and closed within an appropriate timescale. Additional 'Duty of Candour' training sessions have been established during February and March 2023 to ensure classification of harm is addressed appropriately by those reporting (a recording of this session is available to staff unable to attend).Clinical Service Groups to implement a structured process to share learning from incidents. Complete a TNA for all staff investigating incidents to ensure appropriate training has been received.	May-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23
222316	Incident Management	Reasonable	Director of Nursing and Midwifery	Assistant Director of Quality and Safety	R2	Management should work towards producing an Incident reporting Standard Operating Procedure which will bring together (in one place) a standardised and clear system.	Production of an incident management framework.	Jun-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23
222316	Incident Management	Reasonable	Director of Nursing and Midwifery	Assistant Director of Quality and Safety	R3	Acknowledging that developing the datix and incident reporting section of the SharePoint site is a work in progress, management should ensure datix and Incident reporting related pages are reviewed to ensure relevance and ease of use.	Review the reporting section of Sharepoint to ensure appropriate and up to date information is contained within it.	Apr-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23
222316	Incident Management	Reasonable	Director of Nursing and Midwifery	Assistant Director of Quality and Safety	R4	Management should ensure there is periodic monitoring and reporting of incidents in place at the required forums. Groups should also review and update their ToR as required.	Review reporting structures to ensure consistency and robust reporting processes	Apr-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23
222316	Incident Management	Reasonable	Director of Nursing and Midwifery	Head of Nursing and Midwifery	R5	As a form of good practise, management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence. Through other audits undertaken, we have seen this as an area of good practise.	Review the structures in place within the service groups	May-23		Not yet due		No progress							#NUM!	#NUM!	Mar-23	Mar-23

222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure and Cyber Security	R1	**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**	Jun-23		Not yet due		Partially complete		**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**		#NUM!	#NUM!	Mar-23	Mar-23
222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure & Cyber Security and ICT Service Delivery Manager	R2	**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**	Apr-23		Not yet due		Partially complete		**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**		#NUM!	#NUM!	Mar-23	Mar-23
222317	Cyber Security	Limited	Director of Finance, Information and IT	Head of Infrastructure and Cyber Security	R3	**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**	Apr-23		Not yet due		Partially complete		**RECOMMENDATION DETAILS NOT SUITABLE FOR PUBLIC DOMAIN DUE TO THE SENSTIVE CONFIDENTIAL CONTENT**		#NUM!	#NUM!	Mar-23	Mar-23

ITEM 3.9iv APPENDIX G - EXTERNAL AUDIT RECOMMENDATIONS THAT REMAIN OUTSTANDING

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?					
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. Feb 2023 update - status remains as reported above, the action will form part of the 2023/24 work programme which will consider the most appropriate mechanism to achieve the aims and objectives of a Healthcare Professionals Forum. REVISED DATE REQUESTED of 30/9/23. April 2023 update - udpate as above in Feb 2023. The recommendation has been reinforced in the 2022 Structured Assessment report. A decision will be made and implemented by tjhe revuised due date of Sept 2023.	Delayed in light of COVID-19 and changes in the corporate team	Clinical and Stakeholder engagement is undertaken via other means	30-Sep-23		41	24	Mar-23	
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 Feb 2023 update - as above in R2, REVISED DATE REQUESTED of 30/9/23. April 2023 update - as above in R2.	See R2 above	See R2 above	See R2 above		12	1478	Mar-23	
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		The Oracle financials ledger system was used for the 2021 22 Charity Accounts. Due to capacity constraints within the team (long term sickness) extending to include ordering and electronic payments to be implemented during the 2023-24 financial year.	This work is being prioritised for completion.	Governance and control maintained during system implementation	Anticipated end September as planned		6	6	Mar-23	Jun-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R2	Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.		Mar-23		Overdue		Partially complete		Checklist completed with presentation at Audit Committee planned.					#NUM!	#NUM!	Mar-23	Nov-22
222303	Review of the Strategic Renewal Portfolio		Director of Planning and Performance		R1	Independent members were engaged in the development of the Annual Plan for 2021-22 and the renewal priorities. However, since this time there has been a change in the independent member cadre. The Health Board should refresh the independent member awareness. This would ensure new and existing members have continued ownership, knowledge, and challenge.		Ongoing		Overdue		Partially complete		As part of IMTP planning for 23/24 and the wider focus on system working, PTHB has embarked on a piece work look at long term sustainability of services. This piece of work titled "Accelerated Sustainability Model" will include a review of our Strategic Renewal Portfolio. IM's have been fully involved in the production of the 2324 Integrated Plan through a series of Board Development Sessions that started in Oct 22 and finished in March 23			By end of Mar 23		#VALUE!	#VALUE!	Mar-23	Jan-23

ITEM 3.9v APPENDIX H - EXTERNAL AUDIT RECOMMENDATIONS NOT YET DUE FOR IMPLEMENTATION

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?					
222301	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.	Ongoing		Not yet due		Partially complete		Process has been reviewed and an EIA process now in place and being rolled out across teams	None		fully rolled out by Qtr 1 2023/24		#VALUE!	#VALUE!	Mar-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R1	All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.		Ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	Mar-23	Nov-22
222302	The National Fraud Initiative in Wales 2020-21		Director of Finance, Information and IT		R3	Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.		Ongoing		Not yet due		Partially complete							#VALUE!	#VALUE!	Mar-23	Nov-22

Audit, Risk and Assurance Work Programme – 09.05.23

The work programme has been drafted, reflecting on the Committee Terms of Reference, review of last years work programme and in discussion with the lead executive.

The Committee is asked to provide comment on the work programme draft, noting it will evolve throughout the year in response to changing needs, ahead of it being provided to the Board on the 24 May.

Theme	Item	Purpose	16.05.23	12.06.23 Accounts	11.07.23	10.10.23	09.01.24	12.03.24
Governance	Minutes of previous meeting	Approval	✓	✓	✓	✓	✓	✓
	Declaration of Interests	Governance						
	Action Log	Approval	✓		✓	✓	✓	✓
	Annual Work Programme	Approval	✓					
	Work Programme	Governance			✓	✓	✓	✓
	Annual Assessment of Committee Effectiveness	Assurance	✓					
	Committee Annual Report	Rec to Board	✓					
	Annual Governance Programme	Assurance				✓		✓
	Audit Recommendation Tracker	Assurance	✓		✓	✓	✓	✓
	WHC Tracker	Assurance	✓			✓		✓
	Register of Interests	Assurance			✓		✓	
	Register of Gifts and Hospitality	Assurance			✓			
	Fraud	Assurance			✓			
	Whistleblowing Report	Assurance				✓		
	Review of Terms of Reference	Rec to Board					✓	
	Review of standing orders	Rec to Board						✓
	Confirmation clinical audit programme in place	Assurance			✓			

Annual Accounts	Approach to the Annual Accounts	Assurance						✓
	PTHB Draft Accountability Report and Financial Accounts (Invite D&P Members)	Assurance		✓				
	PTHB Final Accountability Report and Financial Accounts and Letter of Representation	Assurance	✓					
	Charitable Funds annual accounts	Assurance					✓	
Internal Audit	Head of Internal Audit Opinion Draft	Assurance		✓				
	Head of Internal Audit Opinion Final	Assurance	✓					
	Internal Audit Annual Plan	Approval						✓
	Internal Audit Progress Report	Assurance	✓		✓	✓	✓	
	Internal Audit Reports (as required)	Assurance	✓		✓	✓	✓	✓
External Audit	Enquiries of Management and Those Charged with Governance	Assurance		✓				
	External Audit Annual Plan	Approval						✓
	External Audit Progress Report	Assurance	✓		✓	✓	✓	

	External Audit Reports (as required)	Assurance	✓		✓	✓	✓	✓
	Structured Assessment	Assurance					✓	
Counter Fraud	Counter Fraud Annual Plan	Approval	✓					
	Counter Fraud Update	Assurance			✓	✓	✓	✓
	Counter Fraud Reports (as required	Assurance	✓		✓	✓	✓	✓
Finance and Procurement	Single Tender Waivers Annual Report	Assurance	✓					
	Single Tender Waivers	Assurance	✓		✓	✓	✓	✓
	Losses and Special Payments Annual Report	Assurance	✓					
	Losses and Special Payments	Assurance				✓		✓
	Post payment Verification Workplan	Assurance						✓
	Post payment Verification update	Assurance				✓		
Risk	Review of Risk Management Framework	Assurance					✓	
	Review of Risk Management arrangements	Assurance / Rec to Board				✓		
Hosted Bodies	Hosted Body annual report (HCRW)	Assurance						✓